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Abstract

A compilation of selected papers includes the following: comprehensive diagnostic services; pediatric aspects of diagnosis; psychological evaluation of the severely retarded; use of social competency devices; diagnosis of the adult retarded; programing for the severely retarded; nursery school experiences for the trainable; a practical approach to teaching; behavior shaping with the severely retarded; development of communication skills; a speech, language, and hearing program; arts and crafts with preschool children; music activities; activity programs; recreation; and educational evaluation. Also discussed are these topics: medical considerations; the role of the nurse; public health services; pastoral care; boarding home provisions; social services in residential care facilities; a volunteer program in a residential facility; transportation facilities; developing community services; planning local services and programs; programing and the public schools; the needs of the retarded program planning, and satellite programs in rural areas; a project in Wisconsin; and diagnosis and followup in non-metropolitan areas. (RJ)

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# *Mental Retardation*

## SELECTED CONFERENCE PAPERS

Edited by R. C. Scheerenberger, Ph.D.

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# *Mental Retardation*

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Edited by
R. C. Scheerenberger, Ph.D.

1969

# PREFACE

During the past several years, a number of conferences on mental retardation have been conducted throughout the State. These conferences addressed themselves to the needs of the retarded as they affect a broad spectrum of services and programs, including those provided by diagnostic clinics, day centers, residential facilities, religious organizations, and generic agencies.

The conferences were co-sponsored by the Governor's Interdepartmental Committee on Mental Retardation; the Illinois Department of Mental Health, including the Division of Comprehensive Services and the Division of Mental Retardation Services; and the Illinois Association for the Mentally Retarded. Most of the conferences, as well as publication of selected papers, were supported in part by U.S. Department of Health, Education and Welfare, Public Health Service, Grant No. MRP-15-C66: Implementation of the Illinois Comprehensive Plan for Mental Retardation.

This monograph provides a compilation of selected papers presented at the various conferences for the purpose of enabling a wider distribution of the thinking and experience of knowledgeable persons representing different agencies and disciplines. The papers have been collated under four general categories: (1) diagnosis and evaluation; (2) training programs for the moderately, severely, and profoundly retarded; (3) supportive services; and (4) planning comprehensive programs.

Though the style and content vary considerably, the principles and techniques elucidated in each paper should be of value to everyone serving the mentally retarded. It is also hoped that the papers will serve to stimulate the interest of allied professions and agencies serving children and adults.

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*January 1, 1969*

## Contents

page

Preface ........ iii

### DIAGNOSIS AND EVALUATION

Comprehensive Diagnostic Services in Mental Retardation ........ *Herbert J. Grossman* 3

Pediatric Aspects of Diagnosing Mental Retardation ........ *Irving H. Rozenfeld* 7

Psychological Diagnosis and Evaluation of the Severely Retarded: A Pragmatic Approach ........ *Stanley Cabanski* 11

Use of Social Competency Devices in Programs for the Mentally Retarded ........ *William R. Chambers* 19

Diagnosis and Evaluation of the Adult Mentally Retarded ........ *Melvin Greenstein* 26

### TRAINING PROGRAMS FOR THE MODERATELY, SEVERELY, AND PROFOUNDLY RETARDED

Programming for Severely Mentally Retarded ........ *Charles P. Jubenville* 40

Nursery School Experiences for Trainable Mentally Retarded ........ *R. C. Scheerenberger* 47

A Practical Approach to Teaching Retarded Children ........ *Maxine Wheeler* 61

Teaching the Profoundly Retarded Child Through Behavior Shaping Techniques ........ *Cecil Colwell* 66

Development of Communication Skills in Retarded Children ........ *Julia S. Molloy* and *Byrn T. Witt* 75

Speech, Language, and Hearing Program: Purpose and Techniques ........ *William Gorham* 87

The Preschool Retardate: Growth and Development Through Arts and Crafts ........ *Ronald Berchert* 92

Music Activities for the Severely Mentally Retarded and Preschool Mentally Retarded ........ *Eleanor Lesak* 97

Activity Programs ........ *Nancy Schuler* 102 page

Recreation ........ *Mary Downey* 105

Educational Evaluation of the Child in a Day Center for the Mentally Retarded ........ *Elaine McNab Hoff* 108

## SUPPORTIVE SERVICES

Prominent Medical Considerations in Meeting Special Needs of the Retarded ........ *William B. Bradley* 118

Meeting Special Needs Through Intervention by the Nurse ........ *Barbara Campbell* 125

Public Health Serves the Mentally Retarded ........ *John B. Hall* 130

The Community Looks at Retardation from the Perspective of Total Continuum of Pastoral Care ........ *Raymond A. Hampe* 133

Implications of Family Boarding Home Provisions for the Retarded ........ *Merle E. Springer* 138

Social Services in Residential Care Facilities for the Moderately and Severely Mentally Retarded ........ *Patricia Tate Bertrand* 151

An Organized Bolunteer Program in a Residential Facility for the Retarded ........ *Jean Slocum* 158

Transportation Services for the Retarded ........ *Philip R. Jones* 161

## PROGRAM PLANNING

Basic Considerations in Developing Community Service for the Mentally Retarded ........ *Charles Beck* and *William Murphy* 168

Planning Local Services and Programs for the Mentally Retarded ........ *William Sloan* and *R. C. Scheerenberger* 174

Programming and the Metropolitan Public Schools ........ *Bernice G. Goodwin* 179

The Needs of the Mentally Retarded in a Rural Setting ........ *Albert J. Shafter* 185

Principles in Rural Planning for the Retarded ........ *Victor P. Wenzell* 190

Project 6 — Wisconsin ........ *Paul Ansay* 194

Diagnosis and Follow-Up in Nonmetropolitan Areas ........ *Donald St. Lawrence* 204

Satellite Programs for the Retarded in Rural Areas ........ *Guy A. Renzaglia* and *Albert J. Shafter* 211

# DIAGNOSIS AND EVALUATION

# COMPREHENSIVE DIAGNOSTIC SERVICES IN MENTAL RETARDATION

Herbert J. Grossman, M.D.

The problem of adequate diagnostic services is exceedingly important, not only for the mentally retarded but for evaluating the overall health status of any person.

What is meant by the term "comprehensive diagnostic services?" How can this be achieved? Why is it needed?

A comprehensive diagnostic examination for the mentally retarded person is an involved process. No one specific discipline can necessarily provide all of the answers. No one discipline engaged in a diagnostic evaluation has a right to any vested interest which would reflect a competence that by definition would place them in a position of being more knowledgeable than other disciplines. In other words, a comprehensive diagnostic evaluation is one that is performed by an interdisciplinary approach, using a variety of skills and techniques that bear on the individual problem as presented.

Using the phrase in its broadest sense, a comprehensive diagnostic evaluation provides the basis for the variety of services for the mentally retarded in rather concise terms; if this is not done, efforts to plan for short-term, intermediate, and long-term goals related to the needs of the patient and his family are not very productive.

Diagnosic services must be related to need. The report of the President's Panel on Mental Retardation (1962) indicated that in 1960 there were 97 special clinics in the United States serving the retarded. The Children's Bureau supports 64 of these clinics, which provide care for about 20,000 mentally retarded children. There were also 1400 psychiatric services and 1400 additional facilities providing some types of diagnostic services. About 40,000 mentally retarded children and adults received care in these various settings. Thus, there are approximately 60,000 individuals served by these various facilities who have received some type of special diagnostic evaluation. This is indeed a very small number when compared to the total number of retarded persons in our society who are in need of these services.

The problems of mental retardation dovetail with other types of handicapping conditions and, of course, the basic health needs of children. If we think of diagnostic services specifically for the retarded, we tend to isolate ourselves from the overall problem of the health needs of the retarded as well as of children generally. This in a sense is harmful

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not only to our own concept of the health needs of our society but to those of the retarded person as well.

The President's Panel on Mental Retardation (1962) also reported that there were roughly nine million children in the United States in 1960 representing 17 percent of the population under 15 years of age who suffer from some type of handicap, many from conditions secondary to their basic disability. Of this number, 350,000 are unable to attend school or play with other children.

These children do not suffer from mental retardation alone and have a variety of other problems. For example, sensory problems are important not only because they occur in a considerable number of retarded persons but also because of the total number of persons afflicted. Between 350,000 and 600,000 children suffer from a significant hearing loss and over two million have a significant type of speech handicap. Several million youngsters are handicapped by eye conditions which impair their educability and adjustment to society.

Why mention these conditions and statistics? The point of emphasis is that we must think in terms of broad comprehensive diagnostic services for children who are mentally retarded and not content ourselves with only defining a mental capacity or a developmental ability. All too often a child is diagnosed as being "mentally retarded," and that is the end of the evaluation. This has caused considerable difficulty in planning for the many types of services that might be necessary at various times during the individual's life.

There are other types of handicapping conditions that become the concern of the professional person as our knowledge about these disorders increases. The types of diagnostic examinations will vary considerably depending upon the presentation of the most prominent problem. A specific professional discipline may have a very major role in diagnosis and evaluation of a child's problems at one age and a very minor role — if any at all — at another stage. As an example, very early in the life of a mentally retarded child the pediatrician may have a considerable role in assessing a given problem. Sometime later when the child is ready for a special program of education, the pediatrician would assume a minor role — if any at all — at which time the educator would have a major responsibility.

With the unfolding of the potentialities reflecting growth and development there must be a constant reassessment of the problem, taking into consideration the individual patterns of growth and development of the retarded person and a constantly changing interaction with his famly and society. Sometimes the problems are primarily medical; sometimes they are primarily psychological; sometimes they are primarily educational; and sometimes they are primarily rehabilitative in terms of specific vocational training.

As diagnostic services for the mentally retarded have developed, they have often reflected the particular interest of one individual and his professional discipline who happens to head a specific clinic or agency rather than the specific problems of the patients who come to that agency for service. It is easy to fall into such a trap, and this has probably happened to many professional persons in an innocent fashion — and, needless to say, such a situation should be avoided.

One of the most serious problems concerned with providing services for the mentally retarded has been the development of standards. Possibly in no other area of the spectrum of health problems have diagnostic standards been compromised as they have for the mentally retarded. Some of this difficulty relates to the historical need for services and the grasping for almost any kind that were available. Unfortunately, in rather zealous efforts to be helpful, many compromises have been made. Substandard professional services should not be tolerated for the problem of mental retardation or for any other type of health problem. For example, communities will not sanction substandard services in the diagnosis and treatment of heart disease or cancer, and we must insist that the same attitudes hold for the problem of mental retardation. We must insist that when diagnostic studies are undertaken that they be done by individuals from the various professions who are well trained and possess sound qualifications. We can no longer allow the situation whereby any individual who becomes interested in the mentally retarded is allowed to establish himself as an expert The diagnostic study of the mentally retarded is often unique. There are many occasions when we think about a diagnostic examination as providing definite answers. We must recognize that probably the most effective and useful diagnostic study will be the second or third or subsequent examinations. In other words, the patient is subjected to a battery of examinations and tests; the family experiences an onslaught of interviews, and we attempt to extract all the information and work out a plan for the future in two or three visits. It is absurd to think that all the answers necessary for long range planning of complex lifetime problems can be given at one time. Timing is very critical. Professionals must be sensitive to the use of certain techniques at certain times. We must recognize that the services of professional individuals should be used wisely. Otherwise, we shall never be able to meet the essential needs of the patient and his family.

Another important point in this discussion is the need for developing mutual respect by the various disciplines for each other's skills, strengths, and contributions. This can only come about by these attitudes being incorporated into their very mode of operation.

Lastly, diagnosis can play a very important part in planning for long range community needs. We know that early diagnosis is important and that many children seen today should have been referred for evaluation at an earlier time. For this reason, diagnostic services should be available and accessible to citizens of all ages in various communities.

Diagnostic services can play a very important part in the accumulation of accurate data. This leads to valuable information that gives us insight into the epidemiology of mental retardation. This, of course, is an important prerequisite for planning for the various kinds of needs that may be present. There is a great need for some central type of organization which would serve such a purpose.

## REFERENCES

President's Panel on Mental Retardation. *National Action to Combat Mental Retardation*. Washington, D. C.: Superintendent of Documents, U. S. Government Printing Office, 1962.

# PEDIATRIC ASPECTS OF DIAGNOSING MENTAL RETARDATION

Irving H. Rozenfeld, M.D.

The accepted definition of *mental retardation* is that of the psychologist who, by psychometric testing, measures the level of intellectual functioning of a child. If the child functions below the 75th or 80th percentile, he is considered to fall within the general category of *mental retardation*. Though this definition is acceptable for purposes of this presentation, mental retardation as a diagnostic category raises semantic problems.

Medically, the term "diagnosis" relates to the determination of a specific pathologic process which causes a set of symptoms, and for which, once the diagnosis is made, a course of therapy is instituted. The term mental retardation is not really a diagnostic term, since there is no disease entity called "mental retardation." At best, the term relates to a single symptom which, evaluated together with other symptoms, signs, and laboratory data may lead to a diagnosis of a specific disease process.

To clarify the statement that mental retardation is a symptom and not a disease, we can compare it to "fever." This analogy is not as farfetched as it may appear. We certainly all agree that there is no disease called "fever," yet, both determinations — mental retardation and fever — are made through relatively accurate scientific measurements, one psychometric and the other thermometric. In both instances, if the measurements are near the mean for the population, the subject is said to be normal. If the measurements deviate from the mean to some significant degree, we are faced with an abnormal situation.

## Role of the Pediatrician

The role of the pediatrician when presented with a child who manifests the symptom of mental retardation is to evaluate the child totally in an attempt to uncover any medical or emotional problem which may lead to retardation of intellectual functioning. The major emphasis of the diagnosis is on those processes that are currently amenable to therapy. Thus, the early diagnosis of such diseases as hypothyroidism, galactosemia, or subdural hematoma may lead to arresting the process leading to mental retardation. Similarly, diagnosis of "autistic reaction" may lead to early psychotherapeautic intervention.

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In the course of a complete medical evaluation, a detailed history is obtained and a thorough physical examination is made. Through the history of the course of the development of the patient; the details of the pregnancy, delivery, and neonatal period; and any familial incident of a similar symptom, the physician is allerted to diagnostic possibilities. Thus, the child who has shown a slow but steady rate of development is not likely to have a degenerative central nervous system disease. In contrast, the child who develops normally until a certain point and then regresses, immediately alerts the physician to the need for certain diagnostic tests.

The physical examination also reveals important clues. For example, children who have enlargements of the spleen and liver may be suffering from a group of metabolic disorders, such as galactosemia or Gaucher's Disease. Children with a mundane disorder such as enlarged adenoids with recurrent otitus media may appear to be retarded only because they are deaf half the time they are in school.

Thus, the pediatrician in his primary evaluation is able to rule out certain disease processes, is alerted to the possibility of others, and makes the necessary determination as to the kinds of laboratory tests and medical consultation that may be indicated.

I would like to stress this last point. An enumeration of a list of tests available and a list of medical consultants that may be needed does not mean that every child who presents the symptom of mental retardation must be seen by every medical consultant or must have every laboratory test. This determination is made on the basis of the patient's history and physical findings. The most flagrant example of ordering a laboratory test without any indication of need is in the commonly given advice by psychologists that a child must have an EEG because the psychological test shows mental retardation due to "brain damage." The EEG is merely the representation of the electrical activity of some of the superficial cortical cells. Thus, an "epileptic" child may have an abnormal EEG and still be extremely bright, attentive, and not have any evidence of perceptual difficulties. Conversely, many retardates, including childen with Down's syndrome (Mongolism) or cretinism, usually have normal EEGs. Most children who fall into the descriptive term of "minimal brain damage" also have normal EEGs. Thus, retardation of intellectual functioning, regardless of the degree of scatter of the subtests and regardless of aberrations on the Bender Gestalt is not *per se* an indication of the need of an EEG.

## Role of the Medical Specialist

The kinds of medical specialists that may be required to evaluate the child further include psychiatrists, ophthalmologists, otolaryngologists, pediatric neurologists, medical biochemists, and geneticists.

The need for psychiatrists, as well as eye and ear-nose-throat specialists, is obvious. The pediatric neurologist is involved since mental retardation is most commonly related to some organic dysfunction of the central nervous system and appropriate therapy can be instituted only after a specific diagnosis is made. For example, there are children who, because of many seizures per day, are functionally retarded because they are not sufficiently conscious to learn anything. Proper seizure control may help these children.

In addition to specific therapies, proper diagnosis is necessary in order to give correct genetic counseling, as well as to relieve parental guilt feelings. Every mother feels that she did not follow her obstetrician's directions to the letter and is, theretofore, the cause of the presenting symptom. If the neurologist is able to pinpoint a specific diagnosis and the etiology thereof, unnecesssary guilt may be alleviated.

## Recent Advances

The newest advances in laboratory tests associated with mental retardation are in the areas of biochemistry and cytogenetics. Each week, someone reports the discovery of a new enzyme deficiency which results in the accumulatioin of some specific amino acid in the blood, which may be toxic to the brain, causing severe retardation. The prime example of this is PKU, but there are many others, such as maple syrup urine disease and histaminemia. The diagnosis is made by measuring the amount of amino acid excreted in the urine and/or the amounts of the specific amino acid circulating in the bood. In some metabolic disorders, removal from the diet of the precursors of these amino acids may prevent retardation.

In addition, other metabolic disorders, such as congenital hypoglycemia and galactosemia, which may lead to retardation, can be diagnosed by specific biochemical tests. Again, it must be stressed that the history and physical examination ususally give the physician a clue as to the possibility of the existence of such disorders.

Cytogeneticists are able to isolate specific chromosomes in an individual. We now know that, whereas the normal person has 46 chromosomes, some individuals have 47 chromosomes. This extra chromosome material is usually associated with retardation. The original discoveries were in Down's syndrome, where the extra chromosome is the 'G' group. Extra chromosomes in other groups lead to equally distinctive features. The point to remember is that we are unable to identify individual genes, and each chromosome has hundreds of genes.

We are currently able to identify only gross abnormalities associated with chromosomal abnormalities. Destructive inherited traits which appear to be on a single gene level, such as Tay Sachs disease, muscular dystrophy, or PKU, cannot be identified cytogenetically. So, here again, the need for an expensive, complicated test must be determined on the basis of a complete medical examination.

While there is no specific medication for mental retardation, such as was suggested some years ago with the advent of glutamic acid, there may be specific medication for the underlying disease process. The cretin must be treated with thyroid hormone; the hypoglycemic may need ACTH; and the galactosemic child or PKU child may need specific dietary management. Certainly, the child with seizures will need anticonvulsant therapy. These therapies, by controlling the underlying disease process, may affect the degree of retardation of the intellectual functioning.

In addition to these specific therapies, many retarded children manifest the symptom complex of hyperactivity, distractability, and short-attention span. These symptoms may prevent a child with normal intellectual capacity from learning. Such symptoms may be devastating to the child who has the additional handicap of mental retardation. Specific drug therapy may, in some instances, alleviate these symptoms. When it does, the results are gratifying. Interestingly, drugs in the stimulant category are often beneficial. They do not act as tranquilizers but appear to mobilize the energies of these children so that their attention span is prolonged, they learn better, and appear to be less active.

## Conclusions

Total evaluation and therapeautic management of the child with mental retardation must be in the hands of the partnership of the physician, the educator, and the psychologist. Each has a very important role to play in every aspect of the care of these children. Only by working together, with each providing that part that he is best qualified to do by virtue of his training and experience, can the child benefit to the maximum. Thus, the physician can prescribe drugs, but without the educator's and the psychologist's evaluations of their effects, there is no way for the physician to know whether or not he is actually helping the child.

# PSYCHOLOGICAL DIAGNOSIS AND EVALUATION OF THE SEVERELY RETARDED: A PRAGMATIC APPROACH

Stanley Cabanski, Ph.D.

One who is involved actively in the psychological evaluation of both the severely retarded and individuals of "normal" intelligence soon becomes aware of certain differences in emphasis regarding the two groups. In evaluating individuals with "normal" intelligence, there is probably more of an attempt made to investigate the global interaction of intellectual, motivational, emotional and social factors which produce the behavior of *this* individual. On the other hand, a diagnosis of severe retardation all too frequently is assumed to cover automatically most, if not all, facets of personality. There is some good reason for this, since, with severely retarded individuals, intellectual disabilities are generally the predominant source of behavioral limitations.

A diagnosis of severe mental retardation, does communicate some meaningful information about a person. It communicates little, however, regarding the unique and individualistic make-up of that person. If one views diagnosis from a pragmatic point of view, the value of a particular diagnosis will be determined on the basis of how useful it is in understanding and working with that individual. Obviously, any attempt at training, developing potential, and planning for a retarded individual will look to diagnoses and evaluations which provide the most useful, specific information about that person.

Psychological diagnosis and evaluation generally involve the use of psychological tests. Tests and testing have, in an important sense, been the applied psychologists' "union card" in terms of their unique contributions to diagnosis and evaluation. This is particularly true in regard to mental retardation. A psychometric definition of *mental* retardation is considered by many both formally and informally as being most meaningful and useful at this time (Clausen, 1957). A tangible, quantitative IQ score can be, and has been, a very attractive basic diagnostic implement in evaluating the retarded.

This psychometric device has, however, not been without its pitfalls. Especially in recent years, psychological tests have come under a heavy barrage of attack. This "antitest revolt" has labeled psychological tests as an invasion of privacy, invalid, unreliable, and generally

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meaningless avenues for understanding and predicting human behavior (Anastasi, 1965). It is beyond the scope of this paper to attempt resolving or even significantly clarifying this issue. Nevertheless, one might adopt a solidly "middle of the road" position and conclude that tests cannot be all bad, but neither are they a panacea for all psychometric ills.

It is likely that some of the confusion regarding tests is the result of misunderstanding on the part of people with little or no training in test construction and psychological theory. Too often test scores and profiles are endowed with meaning far beyond that attributed to them by the individuals who develop testing procedures and techniques. Psychologists have tried to emphasize the limitations of tests; however, their warnings often go unheeded. Attention remains focused upon IQ scores, achievement levels, and behavior profiles.

On the other hand, psychologists cannot be exonerated of blame in their use of tests. Anastasi (1967, p. 297) states, "psychological testing is becoming dissociated from the mainstream of contemporary psychology. Psychological testing today places too much emphasis on testing and too little on psychology. As a result, outdated interpretations of test performance may remain insulated from the impact of subsequent behavior research."

Testing is basically a quantitative tool for measuring behavior. At times, however, psychologists become so enamored with the tool that they are unfaithful to their first love, behavior. For a psychologist to make the most pragmatic use of tests for diagnosis, he must communicate to others, not more information about tests but more information about behavior. Any psychologist, applied or theorectical, experimental or clinical, should have as his main focal point the better understanding of behavior.

In view of the above comments, which hardly scratch the surface as far as the limitations of tests are concerned, one might seriously question (as many have) why tests should be used at all. If psychologists should focus upon behavior *per se,* why not just observe a person's behavior in different situations rather than going through the rigmarole of test construction validation, and administration only to come out with indices, quotients, scores, and the similar which are of questionable meaning? Stutson's (1931, p. 1) comments regarding this question seem apropos:

> "It is said that the most effective tool the artist has is his hands, but the better able he is to combine skill of hand with the use of delicate tools, the finer and the more expressive his art becomes. The most effective tool the child psychologist has is his knowledge of children, subjective though it may be; but this knowledge functions more freely

**and effectively when it is supplemented by tools that enable the psychologist to determine a child's level of development. Any device that renders assistance in this problem of determining the level of development is of value, but the cruder and more inaccurate tools are of much less value than are refined and accurate ones. Standardized tests of all types fall into the classification of useful tools."**

Tests, as tools, sample important behavior and provide a normative guidepost which can serve as a framework within which behavior can be better understood and evaluated. To throw out tests because of their shortcomings would be like "throwing out the baby with the bath water." Test data as samples of behavior are meaningful, the task is to understand their meaning better.

At this point, some discussion is necessary regarding the over-all structure of the testing situation. Although the emphasis is upon the administration of standardized tests the dynamic, interpersonal relationship between examiner and subject, also is involved (Scafer, 1954). At times, psychologists focus too much upon the specific test responses and scores; hence, they miss or lose sight of many facets of clinical data which come to light during the testing situation. The contributions of "field theory," as applied to psychological testing, are helpful in this respect. From this point of view, data of the testing situation include all segments of behavior which the subject exhibits and the interaction between the examiner and subject, as well as specific test responses. Hence, the testing situation as a whole becomes the object of analysis.

Escalona (1948) has suggested specifically that test results should be modified in terms of clinical observations made at the time of testing. He indicates that taking into account concomitant clinical observations may result in different interpretations for the same formal test results; thus, increasing their predictive value. This approach is especially important in testing the severely retarded. The severely retarded characteristically produce a paucity of scoreable test responses. Unless one evaluates the total situation, the data available for analysis will be very limited. In effect, the testing situation is a clinical interview in addition to which specific test responses and scores are obtained that can serve as standardized, normative guideposts.

With the above general factors in mind we can now approach the specifics of psychological diagnosis and evaluation of the severely retarded. The focus will be upon a pragmatic, useful application. What information about a severely retarded individual can a psychologist glean with the help of tests, which will be most useful in terms of evaluating, training, and planning for that individual?

The obvious starting point is in the area of intelligence testing.

Intellectual evaluation presents some immediately apparent difficulties particular to the severely retarded. In the first place, sampling for the standardization of most intelligence tests have included few retardates. Hence, a twelve-year-old individual who attains a 50 IQ on a particular standardized intelligence test does so, not because he functions like other typical 50 IQ twelve-year-olds, but rather because he functions significantly below typical 100 IQ twelve-year-olds. Related to this is the question of what a 50 IQ means, quantitatively and qualitatively, in terms of behavior, especially with respect to the predictive aspects of behavior. In other words, does a 50 IQ mean an individual is one-half as intelligent as a 100 IQ? Will he learn one-half as much as a 100 IQ, or will he eventually learn as much but in twice the length of time? These are obviously questions which cannot be answered at this time.

Before discussing intelligence and intelligence testing further, one should clarify, at least generally, what is meant by intelligence. There is no definition of intelligence; however, in a review of infant and preschool mental tests, Stott and Rachell (1965, p. 42) listed what they considered the three most common meanings: "(1) The genetically determined mental potentiality, (2) the capacity one possesses to acquire new and more adequate modes of behavior and new abilities to function at any particular time, and (3) ones present ability (or abilities) to function, to do, to perform at a particular time".

The first definition refers to "innate" intelligence, whatever that is, and as Anastasi (1967, p. 301) states, "It should be obvious that the relation between the intellectual quality of the individual's behavior at any one time and his heredity is extremely indirect and remote." The second definition refers to the most common type of inference made or implied from intelligence test results: potential to learn and profit from experience. This is an important aspect of intelligence testing and is directed toward prediction of behavior. It is also in this respect, however, that the limitations of intelligence tests come most pointedly into play. The third definition, upon initial consideration, may seem to be the most limited, even in terms of the practical value of intelligence tests. On the other hand, it is most solidly tied to observable behavior.

Speculations about genetic capabilities or future behavior unavoidably involve many variables about which little or nothing is known. That is not to imply that psychologists should refrain from theorizing or speculating about these factors on the basis of observable behavior. Psychological diagnosis will progress only as long as there are continued efforts to test different psychological theories by applying them to different criteria (Stephens, 1966), or by developing new diagnostic tests and methods in accordance with new and changing theories of behavior and development (Flavell, 1963). Nevertheless, to focus upon genetic capabilities or the prediction of future behavior while minimizing the less glamorous but more objective, concrete aspects of what an individual can do is "putting the cart before the horse." If one focuses psychological diagnosis upon what the individual can do at present, the practical applications are numerous.

At times, psychological diagnoses and evaluations can be criticized for accentuating the negative and eliminating positive. It is certainly important, in terms of diagnosis, to pinpoint disabilities; however, when psychological evaluations are to be used for programming and planning it may be more important to know what an individual can do rather than what he cannot do. A teacher or anyone attempting to effect behavioral change needs a starting point within the actualized capabilities of the individual. This, once again, is especially important when dealing with the severely retarded. We have few solid facts regarding the behavioral characteristics of a "typical" twelve-year-old 50 IQ, we know much less about a "typical" twelve-year-old 25 IQ. Any evaluation of a severely retarded individual which can provide us with information about what that individual can do now, especially if this information is anchored by normative, developmental guideposts can be very helpful in working with, and planning for that individual.

If one focuses upon intelligence tests as a measure of what the individual can do rather than what he is potentially capable of doing, periodic administrations of an intelligence test can serve as a measure of change or learning. The efficacy of a particular program of training can be evaluated on the basis of what an individual can do at any given time and what he can do six months or one year later.

Certainly, it goes without saying that the intellectual evaluation of an individual should not stop with the listing of an IQ score, even if the test employed was designed for this purpose. Some differential evaluation of perceptual, motoric, linguistic, cognitive, etc., abilities is definitely indicated. If there is difficulty in communication between the psychologist and those with whom he is trying to communicate with respect to the meaning of such terms as perceptual-motor, cognitive, or linguistic, the psychologist should be more specific and concrete regarding what the individual can do and cannot do (e.g., he can string beads at the three-year level, he cannot copy a diamond at the seven-year level).

One aspect of the process of intelligence testing which probably receives more emphasis when intelligence is defined operationally in terms of what an individual can do now is the procedure of "testing the limits." Since the severely retarded generally produce a minimum of scorable responses and failures far outnumber successes, useful information often can be obtained by exploring failures in terms of their underlying causes. For example, an item on the Binet intelligence test involves placing twelve cubes in front of the subject. The examiner then proceeds to build a "bridge" by placing two blocks adjacent to, but not touching each other and then placing a third block on top. The subject is then asked to "see if you can make one like this." The author has found that at times individuals who fail that item, can successfully build the "bridge" if, instead of placing all twelve blocks in confusion in front of the subject, he is given only three blocks. It is possible that having more blocks than he needs serves as an extraneous, distracting, perceptually confusing element of the situation. At any rate, although a "success" while "testing the limits" does not add to the total IQ score (the item is still scored as failed), some important, specific information is gained regarding what the individual can actually accomplish.

It should be apparent that if one adopts a "field theory" approach to intelligence testing, not only test responses but the overall interpersonal testing situation becomes the object of analysis. The information gained will reflect motivational, emotional, and interpersonal factors as well as intellectual ones. To quote Schafer (1948, p. 18), "test responses, because they represent the subject's style of thinking, allow for inferences concerning predominant features of character make-up". As indicated in the introduction of this paper, these aspects are sometimes neglected in the psychological evaluation of severely retarded. The retarded, in spite of severe intellectual limitations, do adopt characteristic modes of attempting to mediate internal needs with external demands. If we accept as an operational, workable postulate the concept of ego and ego defenses as the mediators which work to harmonize internal needs and external demands, we have a frame of reference within which to evaluate the individual and his unique motivational, emotional and inter-personal styles of adjustment.

One can judge from overt behavior that the severely retarded utilize ego functions and ego defenses quite similar to those of individuals with normal intelligence. Even the severely retarded exhibit characteristically hysterical, complusive, paranoid, etc., features and symptoms. Thus, one may hypothesize that the severely retarded also utilize characteristic ego defenses like repression, reaction formation, and projection as an important part of their ego functions. Hence, the "style" in which a severely retarded individual responds to, for example, an intelligence test can be an important source of motivational, emotional, and inter-personal insight. Furthermore, as long as the individual has some expressive language, personality and "projective" tests can be profitably employed. Meaningful Rorschach records have been obtained from individuals as young as two years of age (Ames, Learned, Metraux, and Walker, 1952).

If the individual has no expressive language, other avenues of personality exploration can be utilized. Play techniques can be a very effective tool for psychological diagnosis. Another useful tool which can be incorporated in the testing procedure is to produce actual situations directed at testing specific behavioral complexes. For example, if the psychologist wonders about an individual's "frustration tolerance," he can frustrate the subject and observe his particular style in responding to the frustrating circumstances. The same procedure can be utilized in testing out reactions to anxiety, aggression, pleasure, etc. Hence, there are no insurmountable reasons why the psychological evaluation of a severely retarded individual should not strive to present an overall picture of the intellectual, motivational, emotional, and interpersonal functioning of that particular person, at that particular time.

## Summary

The purpose of this paper has been to outline some of the practical contributions which psychological diagnosis and evaluation can make toward better understanding, programming, and planning for the severely mentally retarded. The specific contribution of psychological testing in terms of standardized tests and the overall evaluation of the testing situation was discussed.

In spite of the unanswered questions regarding the nature of intelligence and the particular limitations in testing the severely retarded, it is maintained that psychological testing and evaluation can provide useful information regarding intellectual functioning, especially if one focuses upon an operational definition of intelligence, i.e., what a person can do now. Some suggestions were made regarding an approach to a better understanding of motivational, emotional, and inter-personal aspects of the severely retarded through the analysis of ego functions and ego defenses.

## REFERENCES

Ames, L. B., Learned, J., Metraux, R. W., and Walker, R. N. *Child Rorschach Responses.* New York: Hoeber, 1952.

Anastasi, A. Psychology, psychologists, and psychological testing. *American Psychologist,* 22: 297-306, 1967.

Clausen, J. Mental deficiency—development of a concept. *American Journal of Mental Deficiency,* 71: 727-745, 1967.

Escalona, S. K. The use of infant tests for predictive purposes. *Bulletin of the Menninger Clinic*, 14: 117-128, 1950.

Flavell, J. H. *The Developmental Psychology of Jean Piaget*. Princeton: Van Nostrand, 1963.

Schafer, R. *The Clinical Application of Psychological Tests*. New York: International Universities Press, 1948.

Schafer, R. *Psychoanalytic Interpretation in Rorschach Testing*. New York: Grune and Stratton, 1954.

Stephens, W. B. Piaget and Inhelder—Application of theory and diagnostic techniques to the area of mental retardation. *Education and Training of the Mentally Retarded*, 1: 75-86, 1966.

Stott, L. H. and Ball, R. S. Infant and preschool mental tests: review and evaluation. *Monographs of the Society for Research in Child Development*. No. 30, 1965.

Stutsman, R. *Mental Measurement of Preschool Children*. New York: World Book, 1931.

# USE OF SOCIAL COMPETENCY DEVICES IN PROGRAMS FOR THE MENTALLY RETARDED

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A variety of scales and rating devices exist for the purpose of assessing objectively "general social adequacy." The empirical nature of these instruments promises a valid and reliable basis for evaluating progress in programs designed to improve social functioning and for adjusting training activities to the appropriate level of expectancy for retarded children. The purpose of this paper is to describe some of these techniques and provide suggestions for their utilization in special educational programs.

## Background

Socialization in formal special education programs for the retarded child is well accepted as a major educational goal. In fact, Kirk (1964) characterizes "social adjustment, motivation, self-concepts, and so forth" as "the important goals of a special class." These intangible (abstract) concepts offer no immediate suggestions for specific teaching activities calculated to further social development. Particularizing from the general concept of socialization is difficult in that there are degrees of retardation and because social expectancies change with life age. Readiness to learn or to meet the next higher level of social expectancy is related to general maturation, a product presumably of mental age, development, and previous training. Doll (1953), in his summary of studies between intelligence and social development, points out, "The dependence of social maturation upon intellectual maturation is implicit in the measurement of social competence . . . both are dependent on life age."

It is by adapting teaching activities to the level at which the child is functioning, by concentrating on important aspects of social activity, and by providing individualized experiences at a rate the child can accommodate that we propose to help the retarded child reach an optimal level of social adequacy, in spite of his maturational limitations. Because so many factors are involved and interrelated (not the least of which are those individual characteristics of a particular child), we

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have need for considerable help in adjusting training activities to particular children with the broad outlines of a "trainable" or an "educable" program and of monitoring progress to keep activities within the reach of children in our programs. The rest of this paper will attempt to simplify these tasks.

A first step is to particularize the concept of socialization, i.e., we may think of an individual's "socialization" as being made up of social acts (behaviors, habits) in appropriate situations, suitable to his level of development. That is, he does or does not "pull off socks," "put on his coat." "eat with a fork," "say please or thank you," "button buttons." "play checkers, dominoes and similar games according to the rules," "participate in several pre-adolescent games," or "hold a responsible job." Now we have the questions—which of these are important and at which levels of development is it reasonable to expect the child to be able to learn the behaviors? Also, aside from obvious elaborations, what other specific behaviors would be needed to round out the child's social performance? To list these individually would be an enormous task and one of dubious value. What we require is some plan or device whereby we can elaborate or generalize as needed. It is proposed that social competency scales, in conjunction with mental age measures form convenient, readily available guides to selection of appropriate social training activities.

In 1955, Sloan and Birch prepared a schema which provides a rationale for degrees of retardation. Their approach projects brief descriptions of the mentally retarded at four levels of retardation (mild, moderate, severe, and profound), at three life age groupings (preschool, 0-5 years; school age, 6-21 years; and adult age, 21 and over). The descriptions are projected in terms of major life tasks in these age groups: (1) maturation and development, (2) training and education, and (3) social and vocational adequacy. The relationship between degree of retardation, age, and life task can be tied in to the social age concept of the Vineland Social Maturity Scale.

Of course, the obvious use of social competency scales is to determine through periodic re-examination the child's progress and areas of need. for the purpose of modifying instructional experiences.

## The Vineland Social Maturity Scale

The oldest and most studied social competency scale is the *Vineland Social Maturity Scale*. The scale was developed at Vineland Training School (Vineland, New Jersy) over a twenty-year period, and was published originally in 1935. Since that time, it has been researched extensively by Doll, his associates, and other behavioral scientists. In

1953, Doll prepared a text, *The Measurement of Social Competence*, which describes the philosophy, construction, items, administration, and application of the *Vineland Social Maturity Scale*.

According to Doll (1947), the scale provides:

1. A standard schedule of normal development that can be used for measurement of growth.
2. A measure of individual differences.
3. A qualitative index of variation in development in abnormal subjects.
4. A measure of improvement following special treatment, therapy and training.
5. A schedule for reviewing developmental histories in clinical study of retardation, deterioration and rates or stages of growth and decline.

The scale is divided into eight primary areas: (1) self-help general, (2) self-help eating, (3) self-help dressing, (4) self-direction, (5) occupation, (6) communication, (7) locomotion, and (8) socialization.

Location of each item on the age scale was determined empirically, i.e., placing the item at its average value for an age group. The subject does not have to be present during the examination, as the examination is conducted by interviewing one or more persons having prolonged and intimate opportunity to observe the subject's day-to-day functioning. Criteria are provided by which the examiner must determine as a result of his interviewing whether or not the child regularly and reliably performs the activity.

Items are scored + (pass) or — (fail) or ± for items in transitional or emergent state. The scale yields a raw score which is converted to a "social age," which, in turn, may be transformed to a "social quotient" by utilizing the formula:

$$SQ = \frac{SA}{CA} \times 100.$$

Several features of the scale limit its use for comparing relative development in each of the categories. The few items at each level, the probability that the eight areas are not independent, and the fact that similar items do not appear at each age level, discourage pattern analysis. It is possible, however, to identify some of the marked discrepancies which may occur during development. Individuals interested in an extended discussion of the *Vineland Social Maturity Scale* are referred to Doll's text (1953) and to Gottsegen's monograph (1955).

### Residential Development Check List

Bensberg (1965) discusses some advantages to individual evaluation and re-evaluation of children in training programs and offers a combined social competence check list for use by ward personnel. An individual evaluation program—as opposed to a sampling evaluation—possesses several advantages. It may be used to:

1. **Individualize training programs.**
2. **Maintain a record of progress.**
3. **Evaluate training methods.**
4. **Provide valuable information for other professional staff and for parents.**

The *Residential Developmental Check List* provides a simple, effective evaluation device for assessing a child's development in six areas: (1) self-care—eating, bathing, toileting and grooming; (2) motor development; (3) social maturity; (4) language; (5) personality; and (6) occupational maturity.

Though the device is intended to be a readily administered non-normative check list, the average ages at which a normal child performs the various items are provided. This "tagging" makes it possible to approximate the child's achievement on the check list with mental age or social age—a comparison that may be sufficiently accurate for many purposes.

### Cain-Levine Social Competency Scale

Cain, Levine, and Elzey (1963) offer a 44-item scale divided into four subscales:

| | *Name* | *No. of Items* | *Measurement Goal* |
|---|---|---|---|
| 1. | Self-Help | 14 | Motor performance *per se* |
| 2. | Initiative | 10 | Self-directed behavior |
| 3. | Social Skills | 10 | Interpersonal relations |
| 4. | Communication | 10 | Making self understood |

Each of the 44 items includes four or five sub-items, in a scaling arrangement, so that there are 188 scoring possibilities.

**Item 1. Dressing**
- **a. Cannot put on any clothing**
- **b. Can put on most clothing, can zip, cannot button**
- **c. Can put on most clothing, can zip and button**
- **d. Completely dresses self, except for shoe tying**
- **Completely dresses self, including shoe tying**

Internal consistency and test-retest reliability studies produced satisfactory results. The scale was standardized on 716 trainable mentally retarded children in California. IQ's, which were obtained from various sources, ranged from 25 through 59, with mental ages ranging from 2 through 7 years. Correlations between social competency and IQ and between social competency and MA were *low*. One must be alert to the extremely constricted ranges utilized in obtaining the correlations, and keep in mind that such constriction can limit the correlation coefficient. Preliminary data by Congdon (1967), working with trainable males at the Lincoln State School, suggests significant correlations between the Cain-Levine, *Vineland Social Maturity Scale,* and IQ.

The scale yields percentiles for the total scale (and for each subtest) for five age groups (Cain, 1965): (1) 5-0 through 5-11; (2) 6-0 through 7-11; (3) 8-0 through 9-11; (4) 10-0 through 11-11; (5) 12-0 through 13-11.

A longitudinal study by Levine, Elzey, Freeman, and Paulson (1966) indicates some value for the test in predicting success or failure in special class programs. Biserial correlations significant at the .005 level were found between the subtests and selection and survival in trainable classes.

### TMR Performance Profile

DiNola, Kaminsky, and Sternfeld (1963) offer one of the most comprehensive scales for evaluation of performance, all of which would be properly considered elements of social competence. The authors disavow any intent to develop a psychometric instrument similar to techniques for obtaining intelligence quotients, social quotients, and the similar. They set out with a classroom teacher's need to answer the question, "What can the moderately-severely retarded do?" Subsequently, the major areas and items selected for the scale were within the scope of experience and abilities of this retarded subgroup.

Though the prime purpose of the scale was to establish realistic goals for the student in terms of his current level of performance, a scoring system and "Habile Index" (HI) is included to summarize the general level of achievement. The authors discourage inter-individual comparisons in favor of intra-individual comparisons at different times. The scale permits comparative study of the child's level of achievement within the six areas of interest: (1) Social behavior, (2) Self-care, (3) Communication, (4) Basic knowledge, (5) Practical skills, and (6) Body usage.

Each item is offered with five levels of performance:

0. Negative or non-performance or no display of awareness.
1. Minimal performance.
2. Limited acceptability.
3. A realistic goal.
4. Performance above the goal.

The value of the *TMR Performance Profile* appears to rest in the degree to which the authors have been able to describe behavior along a meaningful dimension of approximately "equal" steps and the degree to which items in each sub-heading are interrelated. Differential analysis of relative areas of achievement (or underachievement) is impossible since the assumption of "equal difficulty between items" has not been validated. There is no way to circumvent the criticism that this instrument lacks standardization.

Qualitatively, the scale is adequate and represents the most comprehensive effort of its kind now available. The authors' intention that the profile be used as a guide to goal setting and classroom evaluation is certainly praiseworthy, especially considering the breadth and scope of the effort.

## Discussion and Conclusions

An expository paper of this nature does not lend itself to a series of valid conclusions. However, trends in the assessment of special education programs strongly imply the need to develop teaching-evaluation procedures whereby the teaching effort may be closely monitored.

Kirk (1964) has reviewed studies pertinent to student progress in special class placement, noting the meager findings in support of special education efforts. He points out in this connection the difficulties of evaluating the more intangible but important goals of special education. Other reviews are more critical. For example, Darrah (1967, p. 526) concludes her evaluation:

> Though the procedures used in diagnosing retardation appear to be educationally sound, the next logical step, placement in special classes, cannot be justified on grounds of greater learning, improved social adjustment or more constructive participation in society.

Teachers of arithmetic, spelling, geography, and other content subjects can devise "home made" evaluation devices or utilize prepared standardized techniques to assess progress of their students. The teacher of the retarded faced with the task of teaching "socialization" has a greater problem with respect to evaluation. It is proposed that social competency scales may be used for goal setting and evaluation in which these behaviors subsumed under "socialization" may be particularized and related to the training effort.

## REFERENCES

Cain, L. F., Levine, S., and Elzey, F. F. *Manual for the Cain-Levine Social Competency Scale.* California: Consulting Psychologists Press. Palo Alto. 1963.

Congdon, D. M., The Vineland and Cain-Levine: a correlation study. Unpublished research (in progress). Lincoln, Illinois: Lincoln State School. 1967.

Bensberg, G. J., *Teaching the Mentally Retarded—A Handbook for Ward Personnel.* Atlanta, Georgia: Southern Regional Education Board, 1965.

Darrah, J., Diagnostic practices and special classes for the educable mentally retarded—a layman's critical view. *Exceptional Children*, 33: 523-527. 1967.

DiNola, A. J., Kaminski, B. P., and Sternfeld, A. E. *T.M.R. Performance Profile for Severely and Moderately Retarded—Teachers Manual.* Ridgefield, New Jersey: Reporting Service for Exceptional Children, 1963.

Doll, E. A., *The Measurement of Social Competence,* Nashville, Tennessee: Educational Publishers, 1953.

Doll, E. A., *Vineland Social Maturity Scale—Manual of Directions.* Circle Pines, Minnesota: American Guidance Service, 1947.

Gottsegen, M. G., The use of the Vineland Social Maturity Scale in the planning of an educational program for non-institutionalized low-grade mentally deficient children. *Genetic Psychology Monographs,* 1955, pp. 85-137.

Kirk, S. A., Research in education. In: Stevens, H. A., and Heber, R. (eds.) *Mental Retardation.* Chicago: The University of Chicago Press, 1964, pp. 57-99.

Levine, S. A., Elzey, F. F., and Paulson, F. Social Competence of School and Non-School Trainable Mentally Retarded. *American Journal of Mental Deficiency,* 71: 112-115, 1966.

Sloan, W., and Birch, J. A rationale for degrees of retardation. *American Journal of Mental Deficiency,* 60: 258-264, 1955.

Thornhlen, P. W., A study of on-the-ward-training of mentally retarded children. *California Mental Health Research Monographs,* 1965, pp. 561-562.

# DIAGNOSIS AND EVALUATION OF THE ADULT MENTALLY RETARDED

### Melvin Greenstein

Any discussion of diagnosis and evaluation of the adult mentally retarded must be related to the needs of this segment of the population and must direct attention to how those needs differ from those of the retarded child. As the retardate reaches adolescence and then becomes an adult, he is called upon to make new adjustments and to play a new role in society. Until recently, the community has been ill equipped to help him make the adjustments and to meet his needs.

For the child, the emphasis is on medical and educational evaluation, followed by appropriate treatment. Social development has not yet assumed critical importance. As the child grows, his education becomes increasingly significant in planning. When he becomes an adult, the focus shifts to his vocational and social needs. Emphasis shifts from *within* the family to the retardate's ability to function independently *outside* of the family constellation. At this point, the rehabilitation team assumes diagnostic and training responsibilities with the continued assistance of educators and medical persons.

To set the stage for a diagnostic-evaluative approach to the adult mentally retarded, the centrality of work in our culture must be considered. Dr. William Gellman, Executive Director of the Chicago Jewish Vocational Service, has written extensively about the meaning of work (e.g., 1959). He has pointed out that work life and the productive role are as important as the emotional life for individual well-being in our society. Whether a society is primitive or complex, work and adjustment to work are fundamental. Maintenance of a society is dependent on functional skills which are transmitted from one generation to the next. Power, prestige, wealth, and social rank are related to the occupational role of the person. The very fluidity and mobility of our society has magnified the significance of the occupational role.

For the individual, work may be the primary means for contact with an organized group. Relationships with others may be achieved through the link of productive activity in which work serves as a medium of individual communication with society.

If a person aspires to an approved role in society, he must acquire and utilize competencies which are prerequisites for that role. Ideally, the process of vocational development should lead to vocational maturity and the assumption of a productive role. To be vocationally

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handicapped is to be incapable of participating in the process of vocational development. The mentally retarded, then, may be considered to have an inadequate vocational pattern.

Gellman (1959) defined the vocational pattern as being an integrated whole which combines behavioral and attitudinal elements and includes the following competencies: (1) ability to deal with authority or subordinate figures; (2) ability to deal with co-workers or peers; (3) ability to achieve under pressure or tension; (4) ability to conform to the behavioral norms appropriate to a productive situation; and (5) ability to derive positive meaning in productive activity, in other words, a generalized attitude toward work. The core of the vocational pattern is what work means to the individual.

In order to develop further the notion of a diagnostic approach to the adult mental retardate, we must look at the accepted definitions of mental retardation and their applicability to the older retarded person.

### Mental Retardation: Definition

According to the American Association on Mental Deficiency (1962, p. 3), "mental retardation refers to subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior." This impairment may be in maturation, learning, social adjustment, or some combination of the three. In the early years, delayed maturation is the primary basis for referral to medical clinics. Impairment in learning ability at school age creates a need for specialized educational services. Inadequate social adjustment on the part of an adult creates a need for supportive and remediative vocational and welfare services. Thus, the manifestations of mental retardation may be related to stress — the stress of adjusting to an academic situation, the stress of adolescence, or the stress of learning to make a living.

At the adult level, social adjustment, which is particularly important as a qualifying condition of mental retardation, is assessed in terms of the degree of which the individual is able to maintain himself independently in the community and in employment as well as by his ability to meet and conform to other personal and social responsibilities and standards set by the community.

Within the framework of such a definition, mental retardation describes the *current* status of the individual with respect to intellectual functioning and adaptive behavior. As a result, a person may meet the criteria of mental retardation at one time and not at another. Changing social standards or conditions or changes in efficiency of intellectual functioning may change the status of the individual.

A parallel may be drawn in terms of the mentally retarded person's relationship to the labor market. He may be able to find employment under a given set of market conditions at one time but not at another when employment opportunities become scarce and the marginal person has greater difficulty in finding a job.

What we see is a dynamic definition of mental retardation and an equally fluid approach to the development of vocational patterns and vocational maturation. We see also that social adjustment is of critical importance in finding a place both in the work community and the community at large. Criteria for diagnostic purposes are not easily determined, and standards for evaluation must be used against a background of constantly changing conditions and needs. There can be no absolutes, especially in view of the relative lack of knowledge in the field.

## Purposes of Evaluation

Before we attempt to diagnose and evaluate the adult mental retardate, we must ask: "What are we trying to accomplish?" Some definition of goals is required. If work has a central place in our society, then, the adult mental retardate must be evaluated for his ability to assume the role of a worker. If he can adjust to a work situation, he has taken a long step toward adjustment to the society and the community in which he lives. However, the goal toward which the retardate strives must be his goal, based on what is a realistic goal for him. The broad goal is maximum adjustment to work and to society, but there are qualifications. Maximum adjustment to work may be in the competitive labor market, or it can be in a sheltered workshop, or it may be in a program of activities.

It may even be in upgrading the individual so that he or she is able to assume more responsibilities in the home, thereby releasing some member of the family from a custodial role.

Since we have established that the retarded person must be evaluated against a background of change, it is imperative that we provide a milieu where he can test reality rather than to be measured against static tests. The retarded individual must be observed and diagnosed in action with his peers and with authority figures.

If the stated goals are reasonable, how do we go about ascertaining vocational potential? What steps have to be taken to move the retardate to his maximum level of functioning either at home, in a long-term workshop, or in a job in the regular labor market? What diagnostic tools do we have to do the job, and what do we need? What is rehabilitation, or "habilitation?" What is the rehabilitation staff, what is its role, and how does it function?

The National Rehabilitation Association (1965, p. 18) defines rehabilitation as an individualized process in which the disabled person, professionals, and others, through comprehensive, coordinated, and integrated services, seek to minimize the disability and its handicapping effects and to facilitate the realization of the maximum potential of the handicapped individual." This definition applies to the mentally retarded as well as to persons with other handicapping conditions. It has become accepted to speak of this process as being "habilitation" rather than "rehabilitation" for the retarded so as to eliminate the implication that any former kinds of adequate functioning are being restored. The rehabilitation team devises means to evaluate the individual's vocational potential and to move him toward maximum functioning. The key in diagnosing the adult retardate is *function.*

## Procedures and Techniques

I have taken some time in setting the stage for a discussion of diagnosis of the adult mentally retarded and have raised a number of questions. If we are to diagnose and evaluate, we must examine, analyze, and appraise the needs of the adult mentally retarded with respect to their adjustment to work and to society. From this point, I will try to answer the questions and to describe how my own facility, the Kennedy Job Training Center, approaches the problem of evaluation and diagnosis by building the process around a sheltered workshop setting augmented by the use of a professional rehabilitation team.

The very paucity of criteria led to the evolution of the sheltered workshop from a setting where the disadvantaged could be kept occupied into a diagnostic and training medium. School performance is the criterion upon which the majority of intelligence tests are predicated and against which they are validated. It is questionable whether school curricula and psychological tests are, in any way, related to the conception of work or the role of a worker. Schooling and tests do not necessarily yield an adequate picture of a person's ability to adjust eventually to the setting of the labor market. Even the interviewing process is a one-to-one relationship which demands a verbal facility which the retarded person does not usually have, so that interviewing alone cannot be thought of as an adequate method of discovering a client's work potential, since very often the type of work for which the retarded individual is destined may involve non-verbal performance.

Pioneers in the field discovered that the workshop could encompass broader concepts of diagnosis and evaluation and that other services could be added for the handicapped. The workshop is a milieu in which the realities of work can be encountered and the demands of a work situation can be met. The workshop and the work experience are a situational technique designed to give the client a new environment in which to function, where he can be observed and moved toward increasingly adequate behavior. The workshop adds a new dimension by giving the retardate an opportunity to experience in a simulated work setting true conditions of work. These environmental conditions can be manipulated to expose him to a variety of settings, and through these experiences, the client can begin to evaluate his problems with work as well as his strengths and potential.

In the earlier days of the workshop movement, work samples were used as part of the diagnostic process. These consisted of simulated work tasks, such as sorting, counting, and assembling, that were designed to compare clients and provide a baseline for judging their progress. This approach has been generally discarded in favor of assigning the person immediately to one of the ongoing work activities in the workshop and testing him in a more realistic work situation.

At this point, I would like to direct myself to more specific points about the diagnostic process in a rehabilitation workshop setting. Admittedly this description will be idealized, but the ideal is the goal towards which we strive.

There are a number of applicable prognostic devices. These include the gathering of background information about the client's family, medical history, educational history, and service at other agencies. Psychological tests are used, and the whole combined into an intake report. Observations by the staff of the retarded person's functioning in the workshop are quantified by the use of rating scales; actual productivity is measured against industrial norms.

Since much of the diagnosis is based on the judgment of the people working with the retarded, it is important to know who are the people on our rehabilitation team and what is their professional role in the diagnostic process. Members of this team include the counselor, the social worker, the psychologist, the production supervisor, the teacher in the case of a school-related program, the parents, and the client himself.

The counselor plays a key role in the diagnostic work-up at the Kennedy Job Training Center. In his job description, he is also called the evaluation supervisor and is responsible for coordinating all of the elements of the professional program for the individual client. Out of the information given him by the other members of the team, the counselor designs a plan for the trainee and interprets to him the meaning of his new experiences through the medium of individual and group counseling sessions.

The production supervisor, or foreman, represents reality to the client. Demands for workmanlike attitudes and production on the floor of the workshop come from the foreman. The client is unaware of the professional role of the production supervisor — the manipulation of the environment by withdrawal of support and increasing of demands for increased production, as well as the imposition of limits on inappropriate kinds of behavior. It is the foreman who rates performance and to whom can be traced rewards for better production and industrially acceptable attitudes.

In the Kennedy Job Training Center, the social worker handles the intake process. He sees the applicant and members of his family for an initial interview and gathers the necessary background materials from other sources. When the problems of a client go beyond the development of vocational patterns, it is the social worker who explores with the individual and his family and attempts to analyze and assess the situation. By effective use of casework services, the social worker also is able to help the family of the retarded person to understand his need for identification as a productive member of society and as making a meaningful contribution to the family unit.

It is the consultant psychologist who directs the attention of the rehabilitation team toward those elements of the mentally retarded person's intellectual functioning and his emotional make-up which affect his functioning in a work situation and his adjustment to society. With his diagnosis and assistance, the counselor can introduce into counseling the necessary therapeutic elements.

When the client is referred from a public school special education program, the teacher is included as part of the diagnostic team. Close liaison and presence at staffings helps to compare the retardate's functioning in the school setting and in the workshop.

In a very real sense, the client and his parents are part of the rehabilitation team, if one accepts the definition of rehabilitation previously proposed. The mentally retarded person must be involved actively in the planning, rather than be the object of the efforts of others. His family must understand and accept the plan and offer its assistance.

Central to the philosophy of the Kennedy Job Training Center is the effect a diagnosis of mental retardation has on the adult retardate. What happens to the retardate's self-image and how does this affect his vocational functioning? Emphasis is placed on development of the self-image and on movement toward the best possible adjustment for the individual. Trainees frequently do not have a very positive view of themselves nor do they have a good understanding of the world of work. The counseling program is geared to helping the mentally retarded person obtain a more realistic view of himself by evaluating his strengths and weaknesses and accepting his limitations and assets. Even during the diagnostic period, counseling is built around the polarity of experience on the workshop floor. The client is led to realize that he can experience success and that he is capable of being a productive and meaningful individual.

The policy of the Job Training Center is such that diagnostic and evaluation services should be available to as many retardates as possible, and that few arbitrary obstacles should be permitted in the way of giving diagnostic services. The Division of Vocational Rehabilitation has supported this policy by permitting a six-week evaluation, rather than to rely only on the psychological and academic information that comes along with a referral.

The first significant diagnostic tool with which the client is confronted is a simple application blank which he himself is asked to complete. This reveals the extent to which he can handle himself. Information is later corroborated by the intake worker during an interview with other members of the family and by checking against referral material.

During the initial interview, the intake worker goes through a self-concept check list with the applicant. Instructions are given verbally and are repeated if necessary. Following is the opening statement given by the intake worker: "I want to know how *you* feel about some things. I will make a statement, and I want you to tell me how it applies to *you*. If you think what I say is right, say: "That's right." If it's wrong, say: "That's wrong." If you are not sure, say: "I'm not sure."

There are six categories on the check list: (1) Physical, e.g., "My appearance is all right," and "I have enough strength"; (2) Learning Ability, e.g., "I can remember things easily"; (3) Attitudes and Adjustments, e.g., "I get along with co-workers"; (4) Socialization, e.g., "I have as many friends as most people"; (5) Family and Siblings, e.g., "I get along well with my father"; and (6) Personnel, e.g., "I don't get upset easily."

The last part of the self-concept form has a series of sentences which the applicant is asked to complete. For example:

**I like____________________________________.**
**When I look into the mirror________________________.**
**My family treats me like__________________________.**
**Most people are________________________________.**

Although the form is relatively simple, it provides a profile and a guide to the retarded person's preception of himself for the use of the counselor and workshop staff.

Once the mentally retarded person has entered the program of the Kennedy Job Training Center, he is given an orientation as to the mechanics of participating in the workshop activity. Use of the time clock, assignment to a locker, time for coffee breaks and lunch, and location of washroom facilities may have to be explained more than one time. Early assignments are likely to be to non-demanding jobs so that the trainee may observe what is going on about him.

The major area of concern to the staff is to relate evaluation to a plan for the individual. In observing the client's performance in this work setting, the foremen concentrate on performance, interpersonal relationships, attitudes toward self and toward work, and how the trainee looks as a worker. The realities and the demands of work are met by carefully checking the client's rate of production and quality of work against industrial norms.

An incentive system has been devised for all eligible trainees during both the evaluation and training periods. It combines the elements of developing good work attitudes with a concern for increasing productivity. There are six levels of pay which relate productivity to a series of sixteen points having to do with appropriate work attitudes. These points are:

1. **Talking too much.**
2. **Failure to be at work station on time.**
3. **Just not working hard.**
4. **Not paying attention to the quality of work.**
5. **Wandering around.**
6. **Not asking for help when not sure of how to do a job.**
7. **Annoying others.**
8. **Arguing with the foreman.**
9. **Not willing to do a job he doesn't like.**
10. **Not doing a job exactly as instructed.**
11. **Daydreaming.**
12. **Not keeping his mind on his work.**
13. **Not working steadily.**
14. **Not sitting up and looking like a worker.**
15. **Poor grooming.**
16. **Not being able to get along with co-workers.**

All items relate to the concept of the vocational pattern stated by Gellmen. It is our means of trying to make concrete to the retarded trainee the abstract factors that go into an adequate vocational pattern.

To systematize the evaluation, members of the staff are asked to familiarize themselves with a form which is used to sum up all of the observations at the end of the diagnostic period. The evaluation supervisor, who conducts the staffings, uses the instrument, which is designed to draw attention to all of the cogent factors which have been observed. I would like to take a moment to describe in more detail what is contained in this schedule.

In the section on "Performance," the staff is asked to rate the client's productive ability on repetitious tasks, assembly-line operations, packing and inspecting, aand other types of jobs. Also to be rated is the quality of work in these different areas.

Under "Interpersonal Relations," there is concern with relationship to supervisors and relationships to co-workers. The foremen make a judgment about the trainee's need for supervision and his need for repeated instruction, encouragement, and emotional support. They ask whether he can handle criticism and whether he learns from correction. They are sensitive to whether he functions best under male or under female supervision and to what extent limits must be set for him to work best. In his relations with his peers, the supervisors observe his ability to tolerate annoying co-workers. Also, is he liked and respected? Is he regarded as a leader and active participant in group activities or does he tend to be passive?

The points under "Attitudes" are separated into attitudes toward self and towards work. The staff is asked to rate the client's level of maturity, his level of self-confidence, and his level of self-esteem. Also to be rated are his level of vocational development, his level of motivation to work, his knowledge of the world of work, his knowledge of the roles of a worker and of a supervisor, whether he views himself as a worker, and whether he sees the workshop as a step towards the future.

Finally, the evaluation schedule draws attention to "the trainee as a worker." A series of judgments must be made on the following characteristics:

1. **Can the trainee follow directions?**
2. **Can he sustain work effort for an entire day?**
3. **Can he stay with his work assignment?**
4. **Can he do assignments exactly as instructed?**
5: **Can the individual learn new assignments readily?**
6. **Is he able to work without close supervision?**
7. **Is he able to direct his energies into work?**
8. **Does he derive satisfaction from being productive?**
9. **Can he discipline himself to the extent that he returns to work promptly after breaks?**
10. **Is he able to assume responsibility?**
11. **Can he work under pressure?**
12. **Is he able to organize his work in an efficient manner?**
13. **Is he able to recognize errors and correct them?**
14. **Does he exhibit resourcefulness?**
15. **If he runs into difficulty, does he seek assistance?**
16. **Does he appear to be involved with his work?**
17. **Is it easy for him to move from job to job?**
18. **Will he do a job he doesn't like?**
19. **Will he do any job without complaining?**
20. **Does he conform to rules and regulations of the workshop?**

The evaluation is completed by recording the client's attendance record and by summing up his major strengths and major weaknesses. All of this must result in a *plan* consistent with the individual's own vocational goals. If his goals are unrealistic, the counseling plan must undertake to effect a better understanding of the retardate's capabilities, but in any case, a diagnosis without a plan for movement is meaningless.

The evaluative process at the Kennedy Job Training Center takes place during a six-week period according to a working agreement with the Division of Vocational Rehabilitation. It would be well to point out that we see diagnosis continuing throughout the client's stay in any phase of the program. Evaluation and re-evaluation take place whether the trainee's stay is six weeks, six months, or longer. As a result of the 1965 Amendments to the Vocational Rehabilitation Act, the mentally retarded may be kept in a program of rehabilitation potential determination for as long as eighteen months. This provision recognizes that the assessment of the mentally retarded may be a long, slow process.

In describing how the Kennedy Job Training Center approaches the problem of diagnosing the adult mentally retarded, we have looked at the role of a private voluntary agency in a whole constellation of services. In part, it serves to channel the support of the Federal and State governments into services to the handicapped. While the Division of Vocational Rehabilitation of the State of Illinois underwrites the cost of diagnostic workups for the handicapped, it is often necessary to keep mentally retarded persons in a workshop long after D.V.R. can continue its assistance. The Department of Mental Health has made possible, through its grants-in-aid, continued diagnostic programming for the very limited.

The private, voluntary agency is on the threshold of an increasing role in diagnosis of the adult mentally retarded through cooperative programs with public schools. Establishment of these relationships has been given impetus by the passage of legislation in the State of Illinois requiring additional educational services for the mentally retarded, thus encouraging a linking of special education and vocational rehabilitation. Rehabilitation workshops are in a position to supplement the diagnostic services of the public schools with their own unique contribution to the process, thereby expediting the movement of the retardate from school into the community.

Although much has been accomplished in recent years in creating techniques for evaluating the mentally retarded, much remains to be done and many questions remain unanswered. Not long ago, a person who pioneered in rehabilitation offered the opinion that the current level of knowledge about the vocational adjustment of the mentally retarded is similar to the state of the medical profession in the days when blood-letting was an accepted form of treatment for disease. What we can do now is to raise the questions that perplex us and direct our energies toward clarification of issues.

I call to your attention matters with which we are dissatisfied and which call for greater sophistication on the part of the rehabilitation movement. For example, we do not feel that current diagnostic techniques really allow for individual differences. We are approaching the mentally retarded as a homogeneous group rather than as individuals with a similar type of handicapping condition. We are doing less than an adequate job of identifying emotional problems among the adult mentally retarded and determining to what extent these problems handicap the individual. Could these difficulties, in fact, be more handicapping than the fact of the mental retardation? Up to now, the vocational rehabilitation agency has not stressed the need for differential diagnosis, nor has it seen to it that a plan for remediation becomes an intrinsic part of the evaluative process.

Following the appraisal of the retardate's potential, are we merely going along with the tide and utilizing his minimal talents; or are we really trying to upgrade him vocationally? We appear to be concerning ourselves with simply placing the retarded in jobs. We may be *placing* dishwashers rather than *training* factory workers. In fact, at this time, we do not even have criteria for measuring vocational potential. A review of the rehabilitation literature reveals almost nothing about standards and baselines against which vocational potential can be measured.

One way out of this dilemma is to encourage more and more research. As an example, a number of interesting findings came out of a doctoral study that was done at the Kennedy Job Training Center late in 1965. The typical retardate enters a new situation with a low generalized expectancy for success as a result of a backlog of failure experience in previous situations. The results of this study suggest that work potential of adolescent retardates can be effectively augmented by both internal and social motivational factors. There is a strong implication that unless retarded persons are sufficiently and continually challenged to produce, they tend to produce at a comfortable rate considerably below their potential level. In a typical work training program, two practices prevail. First, efforts to improve performance have been limited to incentives external to the worker. Second, attitudes, knowledge, and skills are imparted primarily by verbal instruction. Much attention has been paid to the structure and content of work experience programs, but little attention has been paid to differential techniques for increasing production, improving quality, or developing attitudes and behavior. As a result, emphasis has been restricted to *what* should be taught rather than *how* it should be taught.

The results of this study raise the kinds of questions in which we are interested and suggest the answers. Should new motivational techniques be introduced early in a diagnostic program? Can we effectively evaluate if we do not adequately challenge the mental retardate to reach for a higher level of functioning?

I seem to be saying that research will answer questions about effective diagnosis by raising an even greater number of questions. I have been told, however, that the key to good research is in asking the right questions and that eventually the answers will follow. The philosophy which we have adopted at the Kennedy Job Training Center is to keep asking questions about the clients, to maintain a flexible posture which enables us to adapt our program to change, and, above all, to keep the needs of the mentally retarded client foremost in our planning.

## REFERENCES

American Association on Mental Deficiency. *A manual on Terminology and Classification.* Monograph Supplement to the *American Journal of Mental Deficiency,* 1962.

Gellman, William. Work as a psychologically common core for social services. *Journal of Jewish Communal Services,* 36(2): 219-224, 1959.

National Rehabilitation Association. An improved role of NRA. *Journal of Rehabilitation,* 31(3): 18-20, 1965.

# TRAINING PROGRAMS FOR THE MODERATELY, SEVERELY, AND PROFOUNDLY RETARDED

# PROGRAMMING FOR SEVERELY MENTALLY RETARDED

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Services for the mentally retarded are everyone's concern and responsibility. Public schools have classes for the educable and trainable mentally retarded; state and private residential institutions provide care, training, and education. There are a number of state-supported day care centers for severely mentally retarded and trainable mentally retarded individuals, as well as a number of such centers operated by local parent groups. Health and other supportive services are provided mentally retarded individuals by state departments of public welfare, state departments of health, and their county and local counterparts. Needs of the mentally retarded in all areas are better recognized now than in the past, and attempts are being made to coordinate efforts of responsible governmental and private agencies to provide not only adequate but superior services for the mentally retarded.

The focus of this paper will be on programming for the severely mentally retarded. Within the past few years, a number of states have passed legislation, usually permissive in nature, to provide training of moderately retarded children in public schools. Several of these states either have changed or are in the process of changing the laws from permissive to mandatory. In Illinois, House Bill 1407 makes it mandatory for public schools to establish classes for the moderately or trainable mentally retarded children by July 1, 1969. Thus, there appears to be a trend toward organizing programs for the severely mentally retarded both in the community and in institutional settings.

The problems of programming for the severely mentally retarded are not as serious or difficult as they might first seem. Experience of several states with state-supported community day care and training centers for severely mentally retarded and trainable mentally retarded has proven that programming for severely mentally retarded can be done effectively. Also, several state institutions have developed such programs, notably those cooperating with the Southern Regional Education Board (Bensberg, 1965).

## Philosophy

There must be a basic philosophy for any society or any institution upon which to establish its goals and objectives. Social philosophy, according to one definition (Good, 1945), is a systematized, more or

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less integrated viewpoint or body of doctrines concerning societal life, the state, the citizen, and related problems. The prevailing philosophy in our society today is that each individual has potential that should be developed. In regard to mentally handicapped individuals, the President's Panel on Mental Retardation (1962, p. 100) stated:

> Every human being has potential for useful activity. Many individuals, ostensibly severely handicapped physically or mentally, possess considerable work potential. . . . There are many other handicapped individuals in whom the potential for useful work is more limited. In some instances, the potential may be so limited that it is insignificant from the standpoint of concern for the welfare and dignity of the individual. The true goal of education and rehabilitation of the handicapped is to help every individual to make the most of his potential for participation in all the affairs of our society, including work, no matter how great or small his potential may be.

Severely retarded individuals have their place in our society. All can be helped to achieve maximum use of their potentials for self-help, self-care, self-direction, and to become socialized individuals within their limitations. It is the responsibility of the programmer to set reasonable goals and objectives based on the needs and potentialities of these severely mentally retarded individuals.

## Goals and Objectives

Goals and objectives for training programs for the severely mentally retarded are based on their needs, capacities, and functioning levels. In general, the severely mentally retarded children have the same basic psychological needs possessed by all children. They need to feel that they are loved, accepted, and part of a group. Their need for affection is great, as is their desire to contribute.

The severely and profoundly retarded also have physical needs, and many are essentially multiply-handicapped. They may be epileptic, cerebral palsied, or blind. Some mongoloids have cardiac conditions. The majority of the severely retarded will reveal balance or ambulation problems. Even those that are non-ambulatory, however, can profit from a properly designed and operated program.

Essentially, the goals and objectives of a training program for these people are habit formation and socialization. A habit, according to Good (1945, p. 197), is "an act, movement, or pattern of behavior that has become familiar, easy, and rapid through practice and training and may be performed without hesitancy or conscious thought — in short, an automatic response to a given situation." The severely mentally retarded, because of intellectual limitations, cannot learn in the usually accepted sense of learning to cope with life situations. They can, however, become habituated to performing numerous socially acceptable activities through repetition — activities which make them more useful to themselves and to others.

Socialization may be thought of as the process of helping the child to understand his limitations and responsibilities; to accept the standards and customs of his family and community; and to cooperate to the best of his ability (Jubenville, 1960). Socialization of the severely mentally retarded individual is important to himself and to others in daily living. A child not only should develop self-respect and self-confidence but also develop a respect for the personal and property rights of others. He must be willing to share responsibilities and privileges commensurate with his capacities. Since the severely mentally retarded child will be a follower all of his life, he must be able to take directions gracefully and act upon these directions appropriately.

Goals or objectives for each severely mentally retarded child in a training program are of two kinds: long range and short range. In order to determine the goals for a particular individual, it is necessary to know what the individual can do and what he needs to develop to make him as self-sufficient as his potentialities will allow.

Basic information needed to develop a training program for a severely mentally retarded individual includes a complete social history, medical evaluation and history, and a psychological evaluation. All possible sources of information should be contacted, and all data received should be reviewed carefully in order to acquire as complete a picture of the individual as possible. Careful attention should be paid to assets as well as to liabilities.

For some severely retarded individuals, it may not be possible to obtain any valid psychometric data in terms of mental age or I.Q. The clinical observations and impressions of the psychologist may, however, be useful. The current functioning level of the individual can be obtained through the use of the oldest social competency scale, the *Vineland Social Maturity Scale*. This scale is divided into eight primary areas: self-help general, self-help eating, self-help dressing, self-direction, occupation, communication, locomotion, and socialization. After administering and scoring the scale, the raw score is converted to a "social age." The social age, in turn, may be converted by formula to a "social quotient."

The *Vineland Social Maturity Scale* has an advantage for the programmer in showing what the subject is able to accomplish currently in each of the eight major areas of social competency. Items failed indicate the retardate's needs for further social development and training. This scale has proven valuable and effective. As Doll (1953, p. 454) stated: "The Scale is specifically useful with feeble-minded subjects as a primary basis of diagnosis and classification, and also as indicating the limits and directions of treatment and the optimum timing for success from training."

## Programming

Development of an individualized training program follows the acquisition of all pertinent data and the determination of appropriate long- and short-range goals. It may be that the most pressing problem the individual presents is toilet training or self-feeding and that socialization, although needed, is not as urgent. Toilet training or self-feeding would become the primary or short-range goal; socialization would be the long-range or secondary goal.

The child's daily training program should be organized to emphasize activities pertaining particularly to the short-range goal. Of course, such activities should be related to those of the group. Small groups are best — a maximum of six severely mentally retarded individuals to one staff member is reasonable, especially when several of the group have toilet-training, self-feeding, and/or ambulation problems.

The environment must be conducive to training activities and schedules for any given group. It should be cheerful, bright, and spacious. It should be large in area. Severely mentally retarded individuals generally need more activity space in which to operate than do normal children in an educational setting. To illustrate, retardates with balance and ambulation problems require more than the normal amount of space in which to operate. Some programmers for severely mentally retarded children have listed required activity floor space per child from 60 to 100 square feet exclusive of service areas, e.g., toilets, cloak rooms, and kitchens.

Toilets should be immediately adjacent to the classroom or activity area, since toilet training is a problem for the majority of the younger severely mentally retarded children. Toilets should be large enough to accommodate several potty chairs for those children who, for some reason, are unable to use standard fixtures.

Equipment, such as furniture, should be fitted to the child's size. An ill-fitting chair and table which causes physical discomfort and weariness will negate much of the training program. A child must be physically and emotionally comfortable to get the most from his training program. Other mobile equipment, such as tricycles and cars, also should be fitted to the child's size.

A wide variety of materials should be provided, some of which should be readily accessible to the group, e.g., puzzles, form boards, lacing shoes, buttoning frames, lacing frames, zipper frames, and other types of educational and recreational toys. Puzzles should be provided in sufficient quantities to provide for variety and complexity.

The daily program for young, severely mentally retarded children should be highly structured and presented in a controlled environment. The program should provide for alternating sedentary activities and physical activities. It should provide for a wide variety of seat work activities with puzzles and educational toys for short periods of time. Because severely mentally retarded children have very short attention spans, especially among the younger age groups, it is necessary to change seat work activities often. This may involve as simple a procedure as exchanging a puzzle for a toy telephone. It is not essential that all children in the group have the same kind of instructional material with which to work at the same time.

Seat work should alternate at fairly frequent intervals with such physical activities as free play or simple circle games of low organizational skill and ability. Again, a variety of activities should be provided until attention spans begin to lengthen.

Music plays an important part in training severely mentally retarded children. A record player and a wide selection of records can be used for both sedentary and physical activities. Children can be taught to bring their chairs and form a circle around the trainer and the record player for either "listening" music, during which they must be quiet and relaxed, or "listen and do" music, which may elicit considerable activity. Some records will help the child name parts of his body, while others will help him identify sounds. Numerous records are available which are enjoyable and, at the same time, help promote better physical development and coordination.

The daily schedule should provide for the various training activities needed by individuals in the group. It should provide "potty periods" for those in need of toilet training. Such periods should be maintained at the same time every day in order to inculcate and reinforce proper toilet habit. This is also true for self-feeding periods. Regularity, repetition, and routine are essential for instilling proper habits in severely mentally retarded children.

A habit, as noted earlier, is an automatic response to a given situation. There are certain principles that trainers of severely mentally retarded individuals should recognize. Persistency, consistency, and continuity are vital to the training program. Persistency on the part of the trainer is essential. The same activities should be carried out daily for weeks and months until the desired goal is attained.

Consistency is necessary, i.e., always do the same thing in the same way. For instance, changing the order of sequential steps in undressing from day to day is confusing to the child. Saying "yes" today to a child when he wants to show off when visitors arrive and saying "no" tomorrow when no visitors are present is confusing.

Continuity of program is important. Severely mentally retarded children require longer and more intensive training periods than those at other levels of mental retardation. These children also forget faster. A continuous, year-round program with as few interruptions as possible due to illnesses or vacations is best for the severely mentally retarded in establishing basic habits and in refining and reinforcing habits.

Maturation and readiness of children should be observed carefully by the trainer. As a severely mentally retarded individual shows signs of readiness for a more complex task or a more complex step in a process, the trainer should present the activity with appropriate materials and much encouragement. Readiness may be expressed by a willingness or desire to try something new. Frequently, readiness may be fostered by the trainer when he observes the child to be bored with a task or is completing the task very quickly.

Severely mentally retarded children must be given opportunities to learn and to acquire self-sufficiency habits. Often, well-meaning mothers or attendants in institutions do too much for the severely mentally retarded individual. There are a number of reasons for this. Some feel that the severely mentally retarded cannot learn; others feel sorry and do everything for him; others are pressed for time (or so they think). Subsequently, they dress, feed, and bathe the child, thereby depriving him of the opportunity to acquire desired and useful habits.

A properly organized training program, based on accurate knowledge of the severely mentally retarded individual's capacities and needs, can assist the individual acquire self-help and socialization habits. The principles discussed above will be helpful in organizing and conducting a training program for severely mentally retarded children.

Another aspect of the training program for severely mentally retarded individuals which should not be overlooked involves the need to evaluate the progress of the severely mentally retarded individual in the group-training program. Again, the *Vineland Social Maturity Scale* (Doll, 1953) can be used effectively to determine the level and rate of progress for each individual. There are other instruments, such as the *Cain-Levine Social Competency Scale* (Cain, *et al.*, 1963), which is somewhat similar to the *Vineland Social Maturity Scale;* the *Trainable Mentally Retarded Performance Profile* (Di Nola, *et al.*, 1965); and the *Residential Development Check List* (Bensberg, 1965). The latter provides for evaluation of self-care skills; motor development;

social maturity and manners; language; personality characteristics; and occupational maturity.

Such evaluative instruments can help the trainer decide whether or not to start a new program and, in some instances, suggest appropriate directions, emphasis, and procedures. Evaluations accomplished by means of these instruments also can be used effectively in case conferences with staff, other interested professionals, and parents. Parents frequently desire, and have the right to know how their child is progressing. Objective data obtained by use of such instruments can be most helpful in discussing programs and progress of a severely retarded individual with his parents.

## Summary

This paper has reviewed basic philosophies underlying training programs for severely mentally retarded persons and has delineated goals and objectives for such programs. Various aspects of programming with respect to habit training have been discussed, including training environment, equipment, and materials; daily training schedules and procedures; and training principles and evaluation.

## REFERENCES

Bensberg, G. J. (ed.). *Teaching the Mentally Retarded.* Atlanta, Georgia: Southern Regional Education Board, 1965.

Cain, L. F., Levine, S. and Elzey, F. F. *Manual for the Cain-Levine Social Competency Scale.* Palo Alto, California: Consulting Psychologists Press, 1963.

Di Nola, A. J., Kaminski, B. P., and Sternfeld, A. E. *T.M.R. Performance Profile for Severely and Moderately Retarded — Teachers Manual.* Ridgefield, New Jersey: Reporting Service for Exceptional Children, 1963.

Doll, E. A. *Measurement of Social Competency.* Philadelphia: Educational Test Bureau, Educational Publishers, 1953.

Good, C. V. *Dictionary of Education.* New York: McGraw-Hill, 1945.

ubenville, C. P. Preschool Programming for the Retarded. In: *Preschool Program for the Retarded Child.* New Brunswick, New ersey: New Jersey Association for Retarded Children, 1960.

# NURSERY SCHOOL EXPERIENCES FOR THE TRAINABLE MENTALLY RETARDED

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A well-conceived, effectively implemented nursery school program can play a significant role in a child's development and formal education. This is true for most children, regardless of their level of intelligence. In fact, research has indicated that such training may be of greatest value to the retarded, especially when they come from emotionally or intellectually impoverished environments.

A brief review of the literature finds a number of studies which have reported that nursery school experiences can result in increased measured intelligence among children in general, e.g., Wooley (1925), Barrett and Koch (1930), Ripin (1933), and Wellman (1940). Other studies, especially those conducted by Skeels and his associates at Iowa (e.g., Skeels and Dye, 1939) and Spitz (e.g., 1945, 1946), demonstrated that changing a young child's environment from one of deprivation to one of wholesome mothering and enrichment could produce marked increments in measured intelligence, even to the extent of ameliorating previously assumed retardation. This does not mean to imply that every nursery school program, or even the best, will effect such drastic changes in behavior. The subjects included in the Iowa studies, for example, came from abnormally sterile environments. In addition, methodological weaknesses tended to vitiate the significance of the obtained results.

Perhaps a study of greater value in terms of the present concern was reported by Kirk in 1958. In this research project, 81 mentally retarded children between the ages of three and six were studied for a period of three to five years. Of these 81 children, 28 participated in a community preschool program, and 15 participated in an institutional preschool program. The remaining 38 subjects served in appropriate contrast groups.

An overall conclusion to this study was that the proferred training experiences did result in improved functioning among the majority of subjects. Of the 43 retardates participating in the preschool program, 30 (70 percent,) made and maintained significant gains with respect to both measured intelligence and social performance.

Of equal importance was the fact that the greatest gains were enjoyed by those children residing in inadequate psycho-social environ-

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ments. As shown in the table below, institutionalized retardates enrolled in the preschool program had an average IQ gain of 10.2; in contrast, the non-participating institutionalized retardates had an average IQ loss of 6.5. Other findings indicated that retardates with organic involvement and those from adequate homes received minimal benefit from preschool training.

PRESCHOOL STUDY: CHANGES IN MEASURED INTELLIGENCE*

| | Experimental Subjects | | | Contrast Subjects | | |
|---|---|---|---|---|---|---|
| | First Preschool Test (mean IQ) | First Follow-up** (mean IQ) | Overall Change | Initial Test (mean IQ) | First Follow-Up (mean IQ) | Overall Change |
| Community Program | 72.5 | 84.2 | + 11.8 | 75.8 | 82.7 | + 6.9 |
| Institution Program | 61.0 | 71.2 | + 10.2 | 57.1 | 50.6 | - 6.5 |

* Adapted from Kirk (1958).
** One year following termination of classroom participation.

On the basis of the cited literature, it can be concluded that, though it is impossible to predict precisely the net value of formal preschool training, it is highly probable that such experience can increase the retardate's functioning and, perhaps, his potential capabilities.

## Generic Goals of Education

In order to discuss and interpret the objectives underlying the activities of a nursery school program for the trainable retarded, it is of prime import to recognize that all education has certain basic commitments. When, as educators, we accept the responsibility for the formal instruction of any child, we also accept those obligations inherent to an education in a democratic society. Education in this country is the expressed and defined right of all children capable of benefiting from such experience; *but* education is also the prime means by which society preserves its status, transmits its heritage, and provides the foundation for further development. In light of this, all education, regardless of the characteristrics of the child or the level of his functioning, is obligated towards the realization of several fundamental objectives.

These objectives have been formulated by various professional organizations and societies. For the purpose of this paper, the seven cardinal objectives defined by the Commission on the Reorganization of Secondary Education (1918) will be cited.[1] Accordingly, it is desired that each child gain knowledge and understanding, skill and confidence, appropriate attitudes and interests, and effective strategies of action relative to: (1) good mental and physical health; (2) a command of the fundamental processes, which includes communication skills, reading writing, and arithmetic; (3) worthy home membership; (4) vocational preparation; (5) citizenship; (6) wise use of leisure time; and (7) character or ethical development.

While these goals serve as a broad foundation for all education, it becomes necessary to interpret their significance in terms of the characteristics of the child being served, his ultimate expectancies, and his present level of adaptive behavior. In other words, one needs to establish a set of meaningful, attainable objectives which will provide a realistic basis for planning and evaluating nursery school training.

## Educational Goals of Nursery School Programs for the Trainable Mentally Retarded

The nursery school program will be considered as one which is concerned with extending appropriate educational erperiences to those retardates between the chronological ages of four and eight years and whose measured intelligence falls within an approximate IQ range of 35 to 50. The corresponding mental age range, taking into consideration both chronological age and IQ, is one and one-half to four years.

The objectives underlying nursery school training for the trainable retarded, discussed in terms of the seven cardinal principles, are as follows:

*Mental and Physical Health* — With respect to mental health, one of the primary objectives of a nursery school program is the development of personally, emotionally, and socially secure individuals. It is generally recognized by psychologists and educators alike that all children possess basic needs for emotional stability. In brief, each individual needs to acquire a sense of (a) self-respect, (b) belonging, (c) success, (d) accomplishment, (e) achievement, (f) recognition, (g) responsibility, and (h) that personal security which can emanate only from a self-understanding and the development of realistic goals. The classroom environment, the teacher's attitudes and capabilities, and the training experiences are all of consequence in satisfying this global goal for emotional security.

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[1] The commonality of all general statements of educational goals, regardless of their intended level, can be demonstrated by examining the objectives established by other highly respected organizations. The Educational Policies Commission of the National Educational Association (1938) divided educational objectives under four main headings: Objectives of Self-Realization, Objectives of Human Relationships, Objectives of Economic Efficiency, and Objectives of Civic Responsibility. More recently, the Mid-Century Committee on Outcomes in Elementary Education (Kearney, 1953) stated that each child should gain a firm background with respect to the following: (1) physical development, (2) individual social and emotional development, (3) ethical behavior, standards of values, (4) social relations, (5) the social world, (6) the physical world, (7) aesthetic development, (8) communications, and (9) quantitative relationships.

With respect to physical health, it is essential that the nursery school extend to the TMR numerous opportunities to develop the basic habits, attitudes, and skills associated with self-care, grooming, safety, and proper nutrition. Psycho-motor development is also of significance to both physical and mental development.

*Fundamental Processes* — Experience to date would indicate that the trainable child rarely attains a functional level of reading, writing, and arithmetic beyond the first grade. It is necessary, however, that the nursery school program begin to lay a foundation for the child to recongize and print his own name and address and become familiar with basic numerical concepts. The major concern of this objective as it relates to the nursery school situation is to provide the child with innumerable opportunities and experiences to develop oral language and related communicative skills.

*Worthy Home Membership* — The trainable child needs to acquire those attitudes, skills, and habits essential to being a desirable, pleasant, and contributing member of his family. This objective is closely related to that of mental health.

*Vocational Preparation* — While the nursery school program for the TMR will not be concerned specifically with formal vocational training, it is necessary to recognize that the basic attitudes and habits involving inter-personal relationships, the ability to attend to the task at hand, the development of a sense of responsibility, and the similar are all important aspects of vocational preparation.

*Citizenship* — Though this goal is interpreted primarily in terms of the child's functioning within his home and school, the nursery school program should begin to provide some exposure of the child to his community and emphasize such important social responsibilities as respecting the rights and property of others.

*Wise Use of Leisure Time* — This goal has limited implications for the nursery school training program; however, many of the play, art, and musical experiences offered within the classroom are transferred to the home and become good leisure-time activities.

*Character or Ethical Development* — The nursery school can play an important role in assisting the trainable child develop desirable standards of behavior. Like all young children, the TMR need to acquire appropriate attitudes and habits relative to honesty, truthfulness, and dependability.

To summarize, the objectives underlying the nursery school program for the trainable child emphasize the development of (1) emotionally secure, socially adaptable children; (2) oral language; (3) basic skills and habits associated with health, self-care, and personal grooming; and (4) a foundation for continual growth in the areas of social and vocational adequacy. These goals provide the basis for the designation of curricular activities.

### Curricular Provisions

Several pages have been included in this report which illustrate the major types of activities usually included in a curriculum for the nursery school, trainable child. It should be observed that these activities are based on a combination of teacher experience and tradition rather than representing the results of controlled, long-term, experimental studies. This does not, in any manner, depreciate the significance of intelligent classroom experience. It does point out, however, that neither the educator nor the psychologist has seriously attempted to develop and perpetuate scientifically contructed curricula We still do not know, with any appreciable degree of knowledge, what activities, introduced at what age, will impede or accelerate learning This, of course, is closely allied with our lack of understanding concerning child development and those variables which positively or adversely affect intellectual functioning.

Prior to proceeding to the actual outline of curricular activities it should be recognized that both the curriculum and its schedule of presentation should be flexible and readily modifiable to meet the needs of the individual student and his environment. Structure in programming is desirable; rigidity is not.

It is also of consequence to realize that much of the knowledge gained by a child in a nursery school is incidental to the actual classroom program. Swift (1964, page 263), in her review of the research related to nursery school programs, stated that "much learning takes place in a non-specific way as the child explores his environment, is exposed to difference types of experience, and has the opportunity to experiment at first hand with many kinds of materials. Behavior that often seems purposeless to the observer supplies the child with basic experiences from which he draws the data to solve problem situations which may arise later."

A second reason for encouraging the nursery school to extend a variety of experiences to the young retardates is theoretical in orientation. According to Piaget, who has been long concerned with the development of intellectual function and logic in children, there are two fundamental processes of learning: *assimilation* and *accommodation*. Assimilation involves the individual's intake of environmental stimuli and experiences; in other words, mental assimilation is the incorporation of sensory data into existing response patterns. Every mental act involves the individual's interpretation of his encountered experiences. In contrast, accommodation refers to the individual's reactions or adaptation to the realities of his environment. Mental accommodation involves the adjustment of the individual's response pattern to the sensory input and to the realities of his world.

Piaget also indicates that the child between the ages of one and one-half and four, or who is within the "pre-operational" period, begins to internalize and symbolize his experiences and concepts of reality. Of great significance at this particular level in the child's development is Piaget's notion of *signifiers* and *significates*. A signifier is an internal representation, such as an image or a word that symbolizes some phase of reality which may be present or absent, real or imagined. The significate is the thing, object, or experience which the child has symbolized. There are two kinds of signifiers: the *symbol* and the *sign*. Symbols are private, highly individualized signifiers. In contrast, signs are those verbal signifiers which have acquired a social meaning and can be communicated to others. Of significance to the nursery school teacher is Piaget's contention that it is the private, personalized symbols which emerge first. The social sign, or the commonly accepted label for an object, is acquired secondly. Thus, it is not the incorporation of verbal signs which initially produces representational thought. According to this interpretation, while the acquisition of language is of utmost importance in the development of conceptual thinking, it does not provide the first or sole basis for such reasoning.

The combination of this concept concerning the role of symbols with the entire process of assimilation emphasizes the need for the nursery school to provide a wide range of experiences and numerous opportunities for the child to experiment and develop a sense of curiosity. Perhaps this is the greatest value of the nursery school.

### Illustrative Curricular Activities

The following outline of activities, stated in terms of what the child is expected to do, is designed merely to give the educator an overview of typical curricular content. The listing is by no means exhaustive.[2]

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[2] Readers desiring a more extensive presentation of curricular suggestions are referred to Rosenweig and Long (1960) and Molloy (1963).

*Social Training*

1. Participate in group activities.
2. Acquire and use basic manners.
3. Learn to share, take turns, and respect the rights of others.
4. Share in the responsibilities of maintaining the classroom.
5. Orally identify members of the family (e.g., mother, father, and brother).
6. Become acquainted with the respective roles of mother and father.
7. Become familiar with common community services (e.g., store and church) and related personnel (e.g., policemen and postmen).

*Oral Language Development*

1. General Vocabulary Development.
   a. Acquire and use words pertaining to making needs known (e.g., eat, hungry, tired, cold, bathroom, and help).
   b. Acquire and use words pertaining to parts of the body (e.g., head, eyes, ears, nose, mouth, legs, and feet).
   c. Acquire and use words pertaining to common courtesies (e.g., please, thank you, hello, goodbye, Mr. and Mrs.).
   d. Acquire and use words pertaining to the home (e.g., kitchen, living room, stove, refrigerator).
   e. Acquire and use words pertaining to the community (e.g., store, church, street).
   f. Acquire and use words basic to common transportation: bus and cars.
   g. Name objects common to the school room (e.g., table, chair, door, toys).
   h. Name objects and animals common to the child's experiences (e.g., flowers, water, trees, common domestic pets).
2. Follow simple oral direction.
3. Describe pictures, including the identification of the objects, scenes, or actions, simple counting, and basic colors.
4. Identify by name the primary colors: red, yellow, and blue.
5. Listen to and retell stories.
6. Participate, whenever possible, in group or individual discussions concerning home or school activities.

*Self-Care and Personal Grooming Skills*

1. Acquire desirable attitudes toward cleanliness and grooming.
2. Learn to wash hands and face properly.
3. Develop appropriate habits relative to the brushing of teeth —

when, how, and care of implements.
4. Keep pointed and foreign objects out of the ears.
5. Dress neatly, change clothes before playing, hang up coats and caps, etc.

*Health*

1. Acquire desirable attitudes towards personal cleanliness.
2. Acquire proper attitudes of skills related to basic eating habits (e.g., do no eat rapidly, do not eat too much, do not gulp food, and avoid eating too much candy).
3. Identify and use properly basic implements of eating, including cup, plate, spoon, fork, and napkin.
4. Acquire basic food vocabulary of such items as cereal, milk, meat, bread, butter and water.
5. Develop basic lavatory skills, including when to go to the bathroom, use tissue correctly, take proper care of clothing, wash hands.
6. Acquire basic habits and skills related to safety (e.g., do not run on stairs, avoid hot radiators, recognition of stop sign, how to cross the street, avoid playing in the street, and basic safety associated with playground equipment).

*Development of Psycho-Motor Coordination*

1. Develop general muscular coordination through such activities as running, skipping, throwing, and playing with such vehicles as tricycle and wagon.
2. Develop finer coordination through pounding activities, puzzles, pegboard, and cutting and coloring.
3. Develop both general and finer coordination through rhythmic activities, such as walking, skipping, hopping, in accordance with a defined rhythmic pattern and/or imitating birds, musical animals.

*Academic Activities*: With the exception of oral language development, the academic area receives only minimal attention.

1. Develop retentive ability:
    a. Improve visual retention through games, such as hide and seek, puzzles, missing parts, recalling visualized objects.
    b. Improve auditory memory through listening activities, stories, poems, rhymes, music, finger plays, and rhythms.
2. Participate in group discussions concerning movies, film strips, daily activities, television programs.
3. Describe action and objects in pictures related to personal experiences.

4. Enjoy looking at and discussing picture books and magazines.
5. Develop discrimination ability:
   a. Visual: match objects by color, form, family, and size; match objects by associated meaning (e.g., head and cap, cup and plate, etc.); find objects and animals and people in pictures; basic psycho-motor activities, such as coloring, pasting, drawing, and tracing; develop some concept of space relationships, including top, middle, and bottom, near and far, up and down, front and back, inside and outside; develop some notion of quantity (e.g., big and little, tall and short, more or less).
   b. Auditory: identify and discriminate between common sounds (e.g., high- and low-pitched voices, loud and soft, the differences between the cat and the dog, the voice of adult and a child).
   c. Tactual: identify and discriminate between such phenomena as soft and hard, hot and cold, and sharp and dull.
   d. Reading: recognize one's own name.
6. Numerical concepts:
   a. Count by rote 1 through 12.
   b. Recognize basic groupings of two to five.

*Vocational Training*

1. Begin to develop those attitudes which are essential to success in any job (e.g., follow directions and take criticism pleasantly; get along well with fellow classmates; desire to do well).
2. Develop habits, such as finishing what is started, practicing good safety habits, and being neat and clean.
3. Accept simple assignments in the room, such as dusting, washing desks, assisting with washing and drying of dishes.

*Creative Expression*

1. Music
   a. Learn simple eight-measure songs, learn simple finger plays, and enjoy singing simple songs.
   b. Experience free rhythmic expresssion, playing rhythmic instruments, imitating a musical animal, moods and tempos, and participating in such activities as marching, skipping, walking, and running to music.
   c. Enjoy listening to a wide variety of musical selections developed especially for the young child.
2. Arts and Crafts
   a. Gain experience with the following materials: crayons,

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temper paint and brushes, plasticine, chalk, construction paper, paste, and scissors.

b. Freely express ideas and feelings through various media.

c. Participate in such general art activities as scribbling on large paper; drawing to music; drawing on the blackboard; painting various lines, forms and free patterns; manipulating clay-coils, balls, pinching and squeezing; cut, fold, tear, paste, and color, using a variety of materials and paper.

*Play Activities*: Engage in a variety of basic play activities, including (a) housekeeping play (e.g., setting table, sweeping, putting clothes on dolly, and dressing up in various adults clothes); (b) sand play; (c) water play; (d) block play; and (e) play with toy animals, dolls, etc., in meaningful situations.

### *Principles Governing Methodology and Implementation*

As is generally recognized, an educator cannot posit within a child any form of knowledge, or even a single bit of information. In fact, the best he can do is: (1) create a motivation for learning; (2) establish an emotionally secure, stimulating atmosphere; (3) provide the child with hopefully meaningful experiences; and (4) introduce the educational program in such a manner that the child, *through his own self-activity,* can increase his knowledge, insight, skills, appreciation, and attitudes. In order to maximize the probability of developing appropriate educational procedures for the nursery school TMR, it is necessary to consider some of the basic learning and developmental characteristics of children within a mental age range of approximately one and one-half to four years.

For this purpose, let us again draw upon the experiences and theory of Jean Piaget. On the basis of his intensive observations of the behavior of his own children and the students enrolled at the Rousseau Institute in Geneva, Switzerland, Piaget postulated that there are four general periods in the development of intellectual thought:

(1) The Sensorimotor Period, which extends from birth to approximately two years of age;
(2) The Pre-Operational Period (2 to 7 years);
(3) The Period of Concrete Operations (7 to 11 years);
(4) The Period of Propositional or Formal Operations (11 to 14 years).[3]

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[3] It is recommended that the uninitiated reader interested in pursuing Piaget's thinking initially consult secondary sources. Piaget's own writings are rather abstract, involving the highly complex language of mathematical logic. Short overviews of Piaget's developmental theory are provided by Wolinsky (1962) and Robinson and Robinson (1965). The most frequently consulted text is by Flavell (1963).

Though the nursery school teacher of the TMR is concerned with the level of pre-operational thought, which most closely parallels the mental functioning of the preschool trainable child, it is necessaary to first review the basic features of the sensorimotor period. During this period, the child progresses from responding on the basis of inborn reflexes to the point of beginning to manipulate and combine images and symbols internally. In essence, by the age of eighteen months, the normal child begins to show the first signs of forethought and planning; however, he tends to deal only with the very concrete aspects of reality and is interested primarily in determining the effectiveness of his responses (i.e., Do they produce the desired effect?)

As previously stated, it is during the pre-operational period that the child begins to internalize and symbolize his experiences and reality. He is beginning to establish a cognitive system capable of transcending concrete reality; in other words, the child can think in terms of the past, the present, and, in a limited sense, the future. He is capable of distinguishing between the real and the hypothetical. Of equal importance, the child now begins to communicatae with others, testing the adequacy of his social responses, as well as his feelings, attitudes, and emotions.

There are still, however, a number of restrictions and limitations with respect to the child's thinking:

(1) The pre-operational child is basically egocentric, i.e., he thinks and acts primarily in terms of himself and his needs.

(2) He remains unable to adopt various points of view concerning a particular problem. He is neither concerned with the consistency of his thought processes nor whether his ideas adhere to any particular social or logical norms. Subsequently, he feels no great need to defend his opinions or to justify his thinking.

(3) Though the child is beginning to think in terms of signifiers and significates, his internal representation still remains at the level where everything is exactly as he perceives it.

(4) Of significance to the educator is the fact that the pre-operational child tends to focus his attention, or "center," on the most interesting aspect of any stimuli or stimulus situation. His lack of ability to "decenter" means simply that he cannot see or understand the integral parts of which a situation or task may be composed.

(5) A further limitation involves the inability of the child to reverse his thinking without producing some major distortion. In other words, the child thinks and proceeds from one

instance, or particular, to another in an irreversible sequence. Piaget believes that this phenomenon of "irreversibility" is the most important characteristic associated with the pre-operational period.

(6) The child's thinking is very rigid; he has yet to see the "grays" of a situation. This is exemplified by his rigid concepts of justice and morality, his difficulty in discriminating between fantasy and reality, and his naive and inadequate notions concerning time, space, number, and quantity.

From these observations and notations of Piaget, a number of principles can be inferred concerning appropriate methodology. For example, the teacher should:

(1) Be specific, direct, and concrete.
(2) Introduce only one activity at a time.
(3) Minimize verbalization when giving directions.
(4) Be sure that the child is attending to the exact desired characteristic of the stimulus being presented.
(5) Program the instructional material into specific, identifiable sub-steps and be certain that the child can progress in a definite sequential manner. Do not expect him to be able to review his thinking or analyze his errors.
(6) Minimize the need for transfer of training. To illustrate, if you wish a child to gain some experience in tying his shoes, do not use the typical shoe-tying teaching aid. Rather, get the child some oversized boots so that he can put them on and learn to lace and tie his shoes in the correct perceptual field. Further, do not expect the child to generalize his learning.

Piaget, like many psychologists and educators, both recognizes and emphasizes the tremendous value of play activities with the pre-operational child. It is through play that the child has an opportunity to express and test newly acquired ideas and concepts. This, in turn, enables him to consolidate his thinking. In addition, play can assist the child in developing his imagination and creativity; it serves as an excellent outlet for emotional expression; and it provides an effective means for the acquisition of social skills and habits. An astute educator can learn much about her students by observing their play behavior.

Another technique, which has proven to be quite successful in working with the young moderately and severely retarded, is based on the principles of operant conditioning. In essence, this technique requires that a task be sequestrated into very small, sequential steps and that the child be rewarded when he makes a correct response. Naturally, the child will tend to retain and repeat those responses that are reinforced and eliminate those which are not. In this manner, the child's behavior is "shaped" into that which is desired.

A number of studies have shown that this technique is particularly useful in teaching social and self-care skills (e.g., Bensberg, *et all.*, 1965; Gorton and Hollis, 1965; and Roos, 1965). An excellent, illustrated description of operant conditioning procedures as applied to the retarded is provided by Stuckey, Breland, and Colwell (Bensberg, 1965) in an instructional manual designed for ward personnel.

## Summary

This paper has attempted to provide a broad overview of the various aspects associated with a nursery school program for the TMR, including its underlying objectives, appropriate curricular provisions, and suggestions relative to methodology. The emphasis was placed on developing emotionally and socially secure, competent children and with providing a wide variety of experiences essential to learning and language development. The discussion of methodology included reference to both the theory of Piaget and the utilization of techniques based on the principles of operant conditioning.

Though the nursery school for the TMR is a relatively recent innovation, its place in the total educational picture is not challenged. Many educators and psychologists, both as practitioners and researchers, are interested in nursery school training with the TMR and suspect that the combination of continued research and practical experience will result in producing a better foundation for the total education of all retarded children.

## REFERENCES

Barrett, H. E. and Koch, H. L. The effect of nursery school training upon the mental test performance of a group of orphanage children. *Journal of Genetic Psychology*, 37:102-122, 1930.

Bensberg, G. J. (ed.). *Teaching the Mentally Retarded*. Atlanta, Georgia: Southern Regional Education Board, 1965.

Bensberg, G. J.; Colwell, C. N.; and Cassel, R. H. Teaching the profoundly retarded self-help activities by behavior shaping techniques. *American Journal of Mental Deficiency*, 69:674-679, 1965.

Commission on the Reorganization of Secondary Education. *Cardinal Principles of Secondary Education*, Washington, D.C.: Superintendent of Documents, Government Printing Office, 1918.

Educational Policies Commission. *The Purpose of Education in American Democracy*. Washington, D.C.: National Education Association, 1938.

Flavell, J. *The Developmental Psychology of Jean Piaget*. New York: D. Van Nostrand, 1963.

Girardeau, F. L., and Spradlin, J. E. Token rewards in a cottage program. *Mental Retardation,* 2:345-351, 1964.

Kearney, N. C. *Elementary School Objectives,* New York: Russell Sage Foundation, 1953.

Kirk, S. *Early Education of the Mentally Retarded,* Urbana: University of Illinois Press, 1958.

Molloy, J. S. *Trainable Children: Curriculum and Procedures.* New York: John Day, 1963.

Ripin, R. A comparative study of the development of infants in an institution with those in homes of low socio-economic status. *Psychological Bulletin,* 30: 680-681, 1933.

Robinson, H. B., and Robinson, N. M. *The Mentally Retarded Child: A Psychological Approach.* New York: McGraw-Hill, 1965.

Roos, P. Development of an intensive habit-training until at Austin State School. *Mental Retardation,* 3:12-15, 1965.

Rosenzweig, L. E., and Long, T. *Understanding and Teachting the Dependent Retarded Child,* Darien, Connecticut: Education Publishing Corporation, 1960.

Skeels, H. M. and Dye, H. D. A study of the effects of differential stimulation on mentally retarded children. *American Journal of Mental Deficiency,* 44: 114-136, 1939.

Spitz, R. A. Hospitalism: An inquiry into the genesis of psychiatric conditions in early childhood. *The Psycho-Analytic Study of Children,* 1:53-74, 1947.

Spitz, R. A. Hospitalism: A follow-up report. *Psycho-Analytic Study of the Child,* 2:113-117, 1946.

Swift, Joan W. Effects of early group experience: The nursery school and day nursery. In: Hoffman, M. D., and Hoffman, L. W. (eds.) *Review of Child Development Research.* New York: Russell Sage Foundation, 1964, 249-288.

Wellman, B. Iowa studies on the effects of schooling. *Yearbook of the National Study of Education,* 39:377-399, 1940.

Wolinsky, G. F. Piaget and the Psychology of thought: Some implications for teaching the retarded. *American Journal of Mental Deficiency,* 67:250-256, 1962.

Wooley, H. T. The validity of standards of mental measurement in young childhood. *School and Society,* 21:476-482, 1925.

# A PRACTICAL APPROACH TO TEACHING RETARDED CHILDREN

Maxine Wheeler

There are many definitions of a "practical approach". In this case, it is defined as the application of research, knowledge, and training to accomplish the most favorable results in the shortest time.

We often are prone to look only at the results of behavior, paying little attention to the processes by which the results were attained. For example, a child that never sits down to eat a meal — instead, he runs around with food in his hand. Without a doubt, this child has never experienced a sufficiently structured environment to see the need to sit down while eating. Often parents unwittingly encourage such inappropriate behavior by providing food that can be eaten on the run. Parents, and even some professionals, often expect the child to "outgrow" undesirable behavior patterns. They forget that *outgrowing* means *learning,* and that learning situations must be developed for the child to accomplish desired behavioral changes. In teaching a retarded child, we never leave anything to chance. Every small detail must be taught.

We, as educators, must *accept* the retarded child with the endowments and limitations which an all-wise Creator has decreed, and we must lead this child toward capacity development, morally and socially, so that he may become a happy, healthy, and self-respecting member of society. We must never lose sight of the fact that this child is first and foremost an individual with wants, desires, and needs. You will note I use the word *accept* — not *tolerate*. There is a vast difference between accepting a child and tolerating him.

## Basic Principles

In teaching a retarded child, you begin exactly as you would if teaching any other child. You must determine what the child can do. What are his assets? We also need to know what he can't do; however, we never dwell upon his liabilities. Rather, we use a positive approach, starting and building upon what he can do.

We can learn most through observing the child. Can he walk? Can he babble? Much time must be spent with the child to learn his strengths and weaknesses.

Before a child is placed in a facility, he usually has been identified and diagnosed as mentally retarded. To say a child is mentally retarded doesn't tell us much. We need a complete diagnosis by a qualified psy-

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chologist to determine the child's specific psychological, educational, and social needs. Also, a physical or medical examination should be made for the purpose of determining possible etiology and need for medical treatment. A comprehensive diagnosis requires a study of the whole child, which includes the integration of the psychologist's findings, the psysician's diagnosis, the social worker's observations, and the family's feelings in regard to their child. It is important to understand the family's expectations for their child in order to view him realistically. Only through a team approach to diagnosis will we gain insight into the degree of the child's retardation, adaptive behavior, developmental and training needs, and social expectancies.

House Bill 1407 makes it mandatory that all public schools provide special education for educable and trainable children by 1969. This means that, during 1969, pupils with IQ's of 35 through 80 can and must be provided for by their own school district. I suspect that private facilities in the future will find it necessary to adapt their curricula for the profoundly and severely retarded.

In studying the developmental characteristics of the mentally retarded, we find two outstanding characteriscs in addition to mental retardation: (1) poor motor coordination and development, and (2) poor speech and language development. Other characteristics may include distractibility, hyperactivity, perseveration, irritability, awkwardness, destructiveness, and aggressiveness. These latter behaviors are relatively common among the brain-injured.

We, in private and public facilities, must teach these children basic self-care skills and habits. These include: eating skills, dressing skills, toilet skills, washing and bathing skills, teeth-brushing skills, taking care of belongings, going-to-bed and getting-up skills, and doing chores around the home.

## A Basic Approach

What is a basic instructional approach? Research by Brace (1948) and Thurstone (1961) demonstrates (if we ever doubted it) that retarded children are far below normal children in motor skills.

As Buhler (1929) points out, organisms with plastic and adaptable systems have to perfect themselves by practice. The early, simple games of the child are intended to develop his sense organs and his motor system. The child experiments with things, looks at them, feels them from all angles, smells them, and taps them to produce sound. Such games may be called games of experience. By the manipulation of things and of his own body in relation to things, the retardate is perfecting the sensorimotor process and is learning to match sensory data to motor data.

Kephart (1960) reports that early motor or muscular responses of the child, which are the earliest behavioral responses of the human organism, represent the beginning of developmental learning. Through these first motor explorations, the child begins to find out about himself and the world around him. In early childhood, mental and physical activities are closely related, and motor activities play a major role in intellectual development. To a great extent, so-called higher forms of behavior have their roots in motor learning.

I am well aware that you can prove anything through research; nevertheless, I believe that the basic approach to teaching mentally retarded children is through a physical education program. In other words, extend the mind through the body. Physical activity for the retarded can affect capacity for thought and action. Physical exercise increases one's feeling of well-being. It makes the retarded child more alert and interested in things around him. If he is more alert and interested in reality, his attention span will increase. He also will benefit from increased self-awareness, more associative perception, and even more thought. Increased effective intellectual potential will rise out of physical activity.

Physical education is no longer a luxury in American education — it is an essential and primary tool in deriving optimal mental development. Study after study indicates that, other things being equal, children who are physically fit perform better and learn more readily than those who are not. Their perceptive abilities are sharper, their responses are quicker, and their capacity for work is greater.

The poet-philosopher Schiller once observed that a human being is at his best in play. This is very relevant to the mentally retarded. It is mostly, if not only, in play that motivation to extend the self is sparked most effectively. In play, there is a strong outburst to stretch to new attainments, to launch into new activity, to attempt new contacts, and to seek mastery of new behavior.

Without activity and guided exercises, a retarded child is likely to have a body manifesting various degrees of sluggishnes and a mind reflecting the body's diminished vitality. In physical play, true and absolute learning potential of the child is activated.

It is well to teach a sequence of motor competencies, following a definite hierarchy of development. For example, exercises involving gross motor deveopment should come first, leading to an active self-conscious image of body control and, finally, to the development of hand and eye coordination.

Mentally retarded children are more uncoordinated and clumsier than normal children. Skills come slowly. It is a good idea, therefore, to have lots of repetition of the various activities. There is no need to try to progress too fast; repetition often means that the child is given an opportunity to enjoy doing something he can do. Repetition increases the performer's own personal satisfaction and gives him confidence. Hyperactive children can be guided into repetition of appropriate physical activity and encouraged to wear themselves down so they sleep more restfully. It is really worthwhile to get tired — it feels good to rest. There is no better tranquilizer than physical tiredness.

Years ago, it was thought that retarded people have supernatural strength. This is not true. According to Hayden (1964), retarded children have only about one-half as much strength as a normal child. They also fatigue 30 percent faster than normal children and carry 35 percent more fat. Few mentally retarded adults participate in outdoor sports or participate as a spectator of outdoor sports. Sixty percent of the retarded have no interest in a hobby of any type or description. The majority of the retarded sampled did little, if anything, constructive with their free time.

A good physical education program should be divided into two parts: (1) individual development and (2) recreation. Contrary to what many people think, retarded children need to learn how to play. Retarded children neither play spontaneously nor innovate as do normal children.

A physical education program does not require expensive material or complicated paraphernalia to be effective. In fact, the utilization of commonplace and available articles are often more meaningful to the child.

### Summary

The following ten points summarize the primary concepts presented in this paper:

1. The facility should have a complete diagnosis of the child, utilizing the team approach to case study.
2. The facility should provide a warm and accepting environment in a sufficiently structured atmosphere.
3. The facility should adapt the training program to the development of the child.
4. The facility should provide for clinical and therapeautic education for special disabilities.
5. The facility should provide an adequate physical education program to insure physical well-being and motor-muscular coordination.

6. The facility should include safety education as a part of the child's training.
7. The facility should provide an adequate diet and foster acceptable eating habits and table manners.
8. The facility should maintain a proper balance between activity, rest, and recreation.
9. The facility should provide contact with and counseling for the parents to aid them in viewing their child realistically and with understanding.
10. The facility should provide systematic and periodic evaluation of the child and his program.

These ten points represent a basic approach to the care, training, and welfare of retarded children.

## REFERENCES

Brace, D. K. Motor learning of feeble-minded girls. *Research Quarterly,* 17(4): 269-279, 1948.

Buhler, K. *The Mental Development of the Child.* London, England: Routledge and Kegan Paul, 1930.

*Hayden, F. J. Physical Fitness for the Mentally Retarded.* Toronto, Canada: Metropolitan Toronto Association for Retarded Children, 1964.

Kephart, N. C. *The Slow Learner in the Classroom.* Columbus, Ohio: Charles E. Merrill, 1960.

Thurstone, T. G. *An Evaluation of Educating Mentally Handicapped Children in Special Classes and in Regular Classes.* U. S. Office of Education Cooperative Research Program, Project No. 168, (6452). Raleigh, North Carolina: University of North Carolina, 1961.

# TEACHING THE PROFOUNDLY RETARDED CHILD THROUGH BEHAVIOR SHAPING TECHNIQUES

Cecil N. Colwell

For a number of years we have relied far too much on results of standard intelligence tests as guidelines for developing training programs for the mentally retarded. Our heavy reliance on the mental age concept has created a psychological barrier for those who have the responsibility of instituting and conducting various education programs.

By using this concept as a guideline, only children within certain IQ's, were considered educable and all below that score automatically were excluded from academic programs. The trainable child was supposed to learn eventually to become independent in self-help areas but not capable of profiting from academic training. Profoundly retarded or "totally dependent" youngsters were thought to be incapable of learning to master skills, such as dressing, feeding, toilet control, or the ability to participate socially with others.

Yet, in our school, as well as others throughout the country, we occasionally would find youngsters who had learned skills and tasks far in advance of what was thought possible on the basis of their IQ or mental age.

One such example is a young man working in our farm program who drives a tractor eight hours a day. He does an excellent job and performs his task as well as an employee. His personal and social adjustment on the cottage is excellent. Not long age, we had a request for a resident who could drive a tractor for extra-mural placement. Our staff immediately thought of this resident. When we pulled his folder and looked at his IQ, we thought there had been a mistake. On the Stanford-Binet his IQ score was 34. He was not supposed to be able to perform at the level he was. It's a good thing the person who taught him the skills he had obtained was unaware the degree of intellectual impairment or this would never have happened.

One well-known authority, when opening a new facility, decided to hire a staff that knew nothing about mental retardation. His reason was that such employees would not have pre-conceived ideas on limits for the children. I am afraid too often when the usual method of

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instruction fails, we assume that the mental ability of the retardate prevented him from acquiring such skills and knowledge.

### Background Information

Research in the last few years has cast doubt on many widely held concepts regarding the limitations of the mentally retarded. In teaching complex skills to retarded youngsters many have used a S-R reinforcement paradigm. Such an approach to teaching is the foundation for programmed learning and the teaching machine.

Ayllon and Michael (1959) found that nurses who used social reinforcement were able to teach desirable social skills to the mentally retarded. Zigler and Williams (1963) found social reinforcement to be more effective in motivating learning with the retarded who came from an environment which was not socially deprived. This illustrates the importance of first having to teach the child to respond to praise and other forms of social reinforcement.

Horowitz (1963) utilized a variety of physical and social rewards to stimulate language development among the retarded. She found that a combination of both was more effective than either type utilized by itself.

Girardeau and Spradlin (1964) used a program based on positive reinforcement to manage and train a group of moderately and severely retarded girls. Tokens were established as generalized reinforcers by making them redeemable in food, soft drinks, jewelry, clothing, and novelties. These tokens were given to the retarded whenever they were engaged in constructive and socially acceptable activities. They found that this method was effective in teaching skills such as bed-making as well as in improving social adjustment.

Ellis (1963) presented a theoretical analysis of this approach and suggested how it might be applied to teach toilet training.

Dayan (1964) applied this method of teaching to a group of profoundly retarded in the area of toilet training. Many of the boys, age six to twelve years with IQ's below 30, were able to learn to use the toilet independently and to remain dry at night.

Bensberg, Cassel, and Colwell (1965) applied this method to teach self-help skills, dressing, toileting, and feeding with six profoundly retarded children. These boys, age seven to fifteen years with an average mental age of one year, could not dress or undress themselves and could feed themselves only with their fingers. After three months of training, they were completely toilet trained, could feed themselves with forks and spoons, and could dress themselves with only minor help. Their social behavior changed even more dramatically. Prior to the training project, the children frequently had to be controlled through physical or chemical restraint. They were unresponsive to verbal commands and had to be controlled through physical force or gestures. After they were in the training cottage for two months, they became more relaxed, more interested in their surroundings, and were anxious to please their cottage parents. Stereotyped behavior tended to disappear, and their level of frustration tolerance was raised. Several boys were taught to complete simple chores, such as to hang up clothing, to make their beds, and to sweep.

## Basic Principles

This method of training involves two major principles. First, it is based upon positive reinforcement or reward. It has been demonstrated that people tend to repeat behavior which is followed by something pleasant or desirable. Behavior which is not accompanied by positive reinforcement tends to disappear or extinguish. How many people would continue to fish if they never caught a fish? How many comedians would we have it they never got a laugh? How many bowlers would we have it one never were reinforced with a strike?

Unfortunately, most retarded children experience little success in life. The result is that most have just stopped trying!! Neither their environment nor the people around them give them much pleasure, because they have not been able to make things work and thus earn from other people a social reward. They do not receive, as do normal children, praise or approval for small things learned. Long sequences of behavior ending in the pleasure of accomplishment are impossible for these children.

The exact, precise use of rewards changed the outlook on life of the retarded with whom we worked. They began to see their world as a nicer place, where people were good and things were fun. No longer were they afraid to face new situations.

The second principle, and the one which has major implications for teaching methods, is based upon the concept of gradually leading the person to make the correct or desirable response by rewarding each improvement. Complex tasks are divided into parts and one part taught at a time. Initially, some persons were rewarded or reinforced for making a response which is only remotely related to that which we ultimately desired. How we break these tasks down into parts and the order in which we teach are extremely important, we have found.

Each task or skill was examined and studied carefully. We began our teaching at the easiest part. We work from the simple to the complex, often from the end back to the beginning, gradually increasing the difficulty of the task. Our approach is based on rewarding successes and every effort is made to keep the child from experiencing failure. When the children fail to learn or succeed, it most assuredly has a profound effect on the teacher as well as the student.

Each child has an individual tolerance level for how long he will try and what he will do to get the reward. The key is to stretch this tolerance level, but not to exceed it.

### Teaching New Steps and Skills

When teaching a new skill, always make sure the child understands what you want him to do. Show him what you want then, help him do it and *reward* him even though you did the most. You might do this several times; then, hold out for some effort on the child's part. *Teach the last step in completing a skill first.*

The standard procedure is based on ten steps:

1. Show him the reward.
2. Give the command and gesture.
3. Give the child time to respond.
4. If he doesn't follow through say "no" and take the reward out of sight. (Make sure he understands the request).
5. After a short time lapse, repeat the above. (Do not repeat the command over and over).
6. If the child doesn't respond, try and determine why. a. Reward not strong enough? b. Is he sick? c. Is he tired or frustrated?
7. When the child responds and while he is doing the request let him know what he is doing by saying it over. (When he is taking off his shirt say "off", "off").
8. Make a big fuss over the child when he responds. Reward *immediately.*
9. Teach one skill at a time, by steps. When they have mastered one step, move to the next.
10. Reward the step you are teaching and the completion of the skill.

Examples of specific task sequences are presented below:

*TAKING OFF PULL-OVER SHIRT*:

COMMAND: "Take off your shirt".

GESTURE: Forward half-moon arch.

STEPS: 1. Take shirt off arm.
2. Take shirt off head and one arm.

3. Over the head and both arms.
4. Off from chest high.
5. Take off completely.

*TAKING PANTS OFF*:

COMMAND: "Take off your pants".

GESTURE: A downward motion with palms down.

STEPS:
1. Pants off except for feet. Have the child step out.
2. Pants up to the knees.
3. Over the knees.
4. From waist.
5. Completely off, thus completing the skill.

*PUTTING ON PULL-OVER SHIRT*:

COMMAND: "Put on your shirt".

GESTURE: A backward half-moon arch.

STEPS:
1. Pull tail of shirt down (shirt is completely on except for pulling it down). Give gesture for down and say "down".
2. Put one arm in.
3. Put both arms in.
4. Pull down over head.
5. Hold shirt and put over head.
6. Pick up shirt and put it on.

*PUTTING PANTS ON*:

COMMAND: "Put *on* your pants".

GESTURE: A sweeping upward motion.

STEPS:
1. Pull up from right below waist.
2. Pull up from above knees.
3. Pull up from above ankles.
4. Hold pants, put one foot in pants leg.
5. Put both feet in pants legs.
6. Pick up pants and put them on.

*TAKING SHOES OFF*:

COMMAND: "Take *off* your shoes".

STEPS:
1. Take shoe off foot (shoe is off heel).
2. Pull off heel.

*PUTTING SHOES ON*:

COMMAND: "Put *on* your shoes".

**STEPS:** 1. Push shoe on heel.
2. Hold shoe in palm of hand and put over toes.

Tennis Shoes:
1. Catch each side of shoe and pull over heel.
2. Catch shoe and put over toes.

### *PUTTING ON SOCKS*:

**COMMAND:** "Put *on* your socks".

**GESTURE:** A sweeping upward motion.

**STEPS:**
1. Pulling sock up from ankle and say "pull".
2. Pulling sock up over heel.
3. Putting sock on toes (place sock over thumbs and guide them over the toes).
4. Holding sock open by self.
5. Picking up sock and finding the top.
6. Complete skill.

### *TAKING OFF SOCKS*:

**COMMAND:** "Take off your socks".

**GESTURE:** Short downward motion.

**STEPS:**
1. Sock is halfway off. Put thumb inside sock and pull off.
2. Sock is completely on; have him take it off, completing skill.

### *PUTTING ON BUTTON-UP SHIRT OR JACKET*:

**STEPS:**
1. Start with the shirt on except for one arm; have child put last arm in and reward.
2. Catch and hold neck of shirt.
3. Putting first arm in sleeve.
4. Holding shirt over sleeve (show child where to hold).
5. Pick up folded shirt and put it on.

### *BUTTONING*:

**COMMAND:** "Button your shirt".

**STEPS:**
1. Pull button (attendant puts button through buttonhole).
2. Hold side of shirt at buttonhole and pull button.
3. Grasp button.
4. Put button in hole.
5. Finding buttonhole and lining it up with the button.
6. Button completely by self.

## *UNBUTTONING*:

COMMAND: "Unbutton your shirt". (Sometimes if they are having difficulty distinguishing between buttoning and unbuttoning, we say "unbutton and take off your shirt" and give the gesture for taking off a button up shirt.)

STEPS: Method I.

1. Hold button and push through.
2. Hold side of shirt and complete skill.

Method II.

1. Flip button (always start at bottom of shirt).
2. Pull button through.

## *PUTTING BELT ON*:

STEPS:

1. Last loop (attendant puts belt on except for the last loop).
2. Next loop.
3. Back loop (if this is too difficult and the child gets frustrated, have him bring belt around to side loop, eliminating this step for now).
4. Side loops.
5. Go to back loop.

## *LACING SHOES*:

STEPS:

1. Take string in hand and push through until they see the tip. They are learning to pull. Any effort toward reaching for the lace should be rewarded.
2. Put the lace into his hand and push it through. They now know to catch and pull.
3. Put the lace in to his hand. He should take it and push it through. He can and will pull it through. Hold the string in palm, "Get the string Roger." If two strings, hold both so they will see you make the choice. Hold his hand and help him make the choice later.
4. Child makes choice, pushes through the string, pulls it out with the other hand.
5. Completes process for all eyelets.

## *TYING A KNOT*:

STEPS:

1. Cross and drop each string.
2. Pick up strings where they are crossed, and hold.

3. Push string through, catch and pull.

Should you want to teach the last step first, just reverse the steps.

*TYING A BOW*:

STEPS:
1. Pull finished bows tight.
2. Catch and pull string which is already through the opening. Tighten the bow.
3. Push string through the opening with the finger and finish bow.
4. Wrap string around, push through and complete.
5. Hold first bow, wrap string around and complete.
6. Make first loop of bow and complete.

### Training Personnel

Who makes a good trainer or teacher? Our experience has shown that neither education nor intelligence is a crucial factor in making a good instructor. The most important factor seems to be that the person be able and willing to adjust to new things. Many persons through long experience in "handling" retarded children have closed their minds to any but their own method. Nothing will change their minds. Such people not only are unable to shape behavior but frequently fight actively against it. A second characteristic necessary for an instructor is the ability to stay on a schedule. Many of the procedures in behavior shaping will not work unless done exactly as they are taught. Third, the instructor must be consistent and even in temperament. The profoundly retarded child cannot adjust to an instructor who is kind and gentle today and irate and irascible tomorrow. Indeed, frequently a loud voice disturbs the children. Fourth, the good instructor can get along with other people. This approach requires team work and the instructor who remains aloof cannot function. Fifth, the instructor must speak clearly and distinctly and he must be adept at using gestures along with his spoken commands. Finally, the instructor must be able to keep an objective attitude toward the child. The instructor who lets the child "get his goat" is worthless. So too is the instructor who becomes so emotionally involved with helping the child that he does for him things he should do for himself.

This method of teaching works and works rapidly. We feel it offers much promise for all levels of retardates; however it does not replace sound principles of supervision and administration. Of equal importance, it does not replace the importance of effort and dedication.

## Summary

This paper has described briefly a successful program for teaching the profoundly retarded at Pinecrest State School, Pineville, Louisiana. The method utilizes a combination of operant and classical conditioning techniques here referred to as behavior shaping. Major principles involved in this teaching method and necessary qualities of a good instructor were discussed.

## REFERENCES

Allyon, T.. and Michael, J. The psychiatric nurse as a behavioral engineer. *Journal of Experimental Analysis of Behavior*, 2: 323-334. 1959.

Bensberg. Gerard J.. Colwell. Cecil N.. and Cassel. Robert H. Teaching the profoundly retarded self-help activities by behavior shaping techniques. *American Journal of Mental Deficiency*, 69 (5): 674-679, 1965.

Cassel. R. H. and Colwell. C. N. Teaching the profoundly retarded self-help activities by behavior shaping techniques. In Bensberg, G. J.. ed., *Teaching the Mentally Retarded*. Atlanta, Southern Regional Education Board, 1965.

Colwell, Cecil N. Attendant training project—Southern Regional Education Board. Paper read at the 89th annual meeting of the American Association on Mental Deficiency, Miami. Florida, May 1965.

Colwell. C. N. Administrative considerations in establishing a training program. in Bensberg, G. J., ed., *Teaching the Mentally Retarded*. Atlanta, Southern Regional Education Board. 1965.

Colwell. C. N. Teaching in a cottage setting. in Bensberg, G. J., ed., *Teaching the Mentally Retarded*. Atlanta, Southern Regional Education Board, 1965.

Dayan, Maurice. Toilet training retarded children in a state residential institution. *Mental Retardation*, 2 (2): 116-117, 1964.

Ellis, N. Toilet training the severely defective patient, an S-R reinforcement model. *American Journal of Mental Deficiency*, 68: 98-103. 1963.

Girardeau. Frederic L., and Spradlin, Joseph E. Token rewards in a cottage program. *Mental Retardation*, 2 (6): 345-351, 1964.

Horowitz, Francis, Partial and continuous reinforcement of vocal responses, using candy, vocal, and smiling reinforcers among retardates. *Journal of Speech and Hearing Disorders*, Monograph Supplement No. 10. 55-69.

Zigler. E.. and Williams, T. Institutionalization and the effectiveness of social reinforcement. *Journal of Abnormal Social Psychology*, 66: 197-205, 1963.

# DEVELOPMENT OF COMMUNICATION SKILLS IN RETARDED CHILDREN

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*Communication* is an exchange of ideas and information. It can be non-verbal, through the use of facial expression or gesture, or verbal through spoken language. *Speech* is uniquely human and is a part of a larger system of symbols that carry meaning. Words are special sounds that are symbols which stand for things and ideas.

We have a system of making sounds into words which carry meaning. Because we live with people who use the same system of symbols we can communicate with them.

The system, the plan, of using words is called *language*. The way we say words is *speech*. The way we use words is *language*.

Since language and communication are important ingredients in the development of mental abilities, programs to improve the language and communication ability of children with retarded development are important.

It has been estimated that approximately 40 percent of learning capacity is linguistic ability. Language development is delayed in most retarded children. Useful and constructive communication is essential to the social, emotional, intellectual and spiritual growth of any child. The process of physical maturation cannot be accelerated; however, the circumstances for stimulating the need for communication can be structured and manipulated to capitalize upon every asset available in the retarded child. Concomitant with the process of maturation is the observed sequence of language development. Basically, the problem is to structure readiness for producing speech by perceptual training and to proceed to induce language functioning on a conceptual level.

The paucity of services in the field of language pathology available to retarded children and their classroom teachers has created a serious problem. The purpose of this paper will be to discuss areas which will assist the teacher in developing and incorporating into her daily schedule

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a realistic, practical, and sequential program for the development of communication skills. An appropriate philosophy; a working knowledge of deterrents to the deveolpment of language; criteria for assessing the child's functioning level of communication; and implications for teaching will be discussed.

## Goals and Objectives

The speech and hearing field only recently has shown much concern for moderately and severely mentally retarded individuals. The first workers to indicate a realistic philosophy for communication were Strazzulla and Karlin (1952, p. 17), who urged the understanding of a basic concept for language therapy with retarded children:

> In working with these children it must be borne in mind that the aim is not to attain perfect speech, but to assist them in developing usable everyday language to the maximum of their ability.

The goal of "everyday language" precludes the use of the term "speech correction" *per se* with retarded children. Speech correction is desired only when language functioning is adequate and the problem involves such areas as articulation or phonation. These latter problems will not distract from, or lessen control of, the content of the verbal output.

## Assessment of Communication Skills

Five major areas must be explored to determine those factors which may be adversely affecting the development of useful communication: hearing, condition of speech mechanism, environmental climate, symbolic functioning, and cognitive ability. The classroom teacher can explore these areas grossly, but usefully, through information provided by the parents, through observation of the child in structured situations, and through comparison of the child's level of communication with normal developmental scales.

*Hearing loss (deafness or partial deafness)*: A hearing loss is not a contributive factor to delayed use of language if the child responds to his name whispered no closer than three feet behind his back. His response may be a smile, arrested activity, or a turn of the head. A suspected hearing loss should be referred to a physician.

Parents can help the teacher to understand how the child *uses* his hearing. Has the child attached any meaning to the sound of running water (bath tub), telephone, door bell? Is he afraid of these sounds? He may be afraid because he has trouble attaching the meaning to sounds he actually hears.

How well does he hear? The retarded child requires intensive auditory training to gain a generous storage of auditory experiences before he can be expected to communicate verbally and spontaneously. Does he profit from auditory experience? If he locates a concealed noise maker, will he seek it in the same location upon a repeated stimulation? Can the child mimic a sound that has meaning (cow says "moo") or repeat a word?

*Speaking mechanism*: A child's speaking mechanism is usable for speech if he is able to do the following: swallow, suck, maneuver his tongue by controlling its action, such as extending, and/or elevating the tip and swinging it from one corner of the mouth to opposite corner, employing some speed in tongue action. This can be observed by having the child repeat "la-la-la."

*Environmental climate*. The child's environment is considered to be favorable to the development of good social language if he has a need to talk (the parents do not anticipate his every need), if there is some stimulation in the home, and if he is neither ignored nor abused.

*Symbolic dysfunction*. Symbolic dysfunction is a strong contributing factor to delayed language functioning of many retarded children. The child may be unable to receive meaning from a spoken symbol (e.g., a word) or a visual symbol (e.g., a pencil). Subsequently, this child has difficulty producing an appropriate act, sound, or word response to a heard or seen symbol. The determining of the extent of symbolic dysfunction is the task of a language pathologist.

Careful guidance through an appropriate program of language development should help the young retarded child attach meaning to sounds and visual stimuli.

*Cognitive ability*: A child cannot be expected to function beyond his level of cognitive ability. It is imperative that the classroom teacher be aware of the scatter of the child's successes and failures in psychometric data. She should know which items from standardized data reveal the child's ability to communicate.

Using a scored "mental age" as a rigid rationale for determining an appropriate starting point to work with a retarded child is precarious and can be disastrous. The classroom teacher must know if the mental age, regarded as an average presentation of cognitive ability, precludes the establishment of a starting point in a communicative program. A mental age below one year in a four-year-old preschooler would indicate that a little more mental growth must occur before a child will be amenable to language therapy.

A word of caution—retarded children are highly individualistic! They don't fit neatly into any single, stratified plan. The language program progresses from one step to another based on a sequential approach designed for each child.

A developmental scale has been included at the end of this paper. It presents a composite in proper sequence of many items from psychometric instruments, standardized developmental and linquistic scales. To find the child's level in language development, the classroom teacher should assemble data from history obtained from parents and previous records, from her own structured observations, and from the psychologist who studied the child most recently.

## Kinds of Communication Problems Found in Day Centers for Retarded

Mentally retarded persons served in day centers vary considerably with respect to both age and degree of retardation. As public schools are assuming the responsibility for most EMR and TMR children, the day centers are moving towards providing services for preschool children, school age children too severely handicapped for public school placement, and post-school age placement. Thus, staff at day centers are finding themselves facing an even wider array of communication problems than they have in the past.

Communication skills of any retarded child can be improved. The average day center child does not have communication and language skills commensurate with his potential cognitive functioning. Individuals with poor communication skills usually have many specific language defects, but, for simplicity's sake, children and adults served in day centers can be grouped according to three categories.

One category is the young (usually 2 to 7 years of age), nonverbal child with retarded development. This child usually presents a complex diagnostic picture and often involves a combination of organic, psychiatric, and learning disorders. Cultural deprivations also can be a factor in many sections of the State. A differential diagnosis is primary before a communication problem can be planned for such a child. The goal for these individuals would be to develop maximum communication skills within the limits of the child's total potential.

A second category might be called the "poor verbal" child. This child usually demonstrates a lag between his receptive language (e.g., understanding and comprehension) and his expressive language or communication. A difference of a year or more in development between reception and expression is very significant. The specific factors need to be pin-pointed, if possible, and a communication program planned with these factors being given primary consideration.

The third type of individual usually seen is the severely or profoundly retarded individual who has low cognitive functioning and usually very little, if any, communication skills. Until recently, most of us did not bother to attempt to train communication, especially verbal communication. Yet, it has been demonstrated that individuals with estimated mental ages of a year or more can communicate verbally at the naming stage. This is more easily done in the institutions where ward aids can work through two or more shifts with these individuals, but it can be accomplished in a day setting. The use of a few words or gestures can make life considerably more pleasant for the retarded individual and those in his environment. In the institutional setting this becomes even more critical.

### Procedures to Develop Communication Skills

We know the kind of child with whom we must work, we hope we have learned the proper starting point and what we are going to do about it. First, we are going to set *realistic goals*. We also must be certain of *readiness*. Is this child really ready to learn to communicate verbally? Does he need more socializing, freedom of opportunity to just be in a group of peers? Are the parents ready and willing to work with us during the long term of auditory training? We feel it is practically impossible to start the long road toward adequate communication if the parents are not ready, willing, and able to work with us.

Before therapy can begin, it is essential to capture the child's attention. He is led to listen through attention-compelling stimulations. This means arresting activities through auditory, visual, and tactile stimulations. We do this through the use of attention-getters, i.e., compelling little gadgets so fascinating that the child cannot resist paying attention.

Using the child's own self as an attention-getter is effective. His attention is directed toward himself. Saying, "Is Donald here? Where is Donald?" The child hearing his own name, will very often smile, then some thing or article can be directed to his attention.

In the early stages of therapy we must *condition responses for safety*. "No", "Come here", "Don't touch", and "Sit down" must be learned long before the sound symbol itself has any conceptual meaning to the child. He must learn to *react* to these words for his own safety and security. We train them through the conditioned response method to react appropriately to "No", "Come here", "Don't touch", "Sit down".

After learning to listen through the attention compelling stimulations, the child learns to listen and *react* to sound. Total body activity is involved. The child runs upon hearing music that stimulates speed, or moves slowly to music or to the tone of the teacher's voice.

The next step is learning to listen and to *respond* to sound. Responding, infers that another person or thing is involved. In learning to listen and to respond to sound, the child is expected to provide an appropriate, non-verbal response, associating word sounds with common objects, such as ball, baby, bus, bathtub. In this way, meaning becomes attached to the names of common objects. The child is not required to say "ball", but is expected to attach the sound of the word "ball" to the round object that our culture has named ball. We do the same things with bus, baby, and other overt words within the child's experience.

At this time, we also are concerned with basic proprioception. The child is expected to listen and respond by showing the teacher where his nose is, where his ears are, where his feet are, and other parts of his body.

We are concerned with identification and location of familiar sounds, such as the passing fire truck, the arrival of the station wagon, the call from another part of the room, the call on the playground to the different children. This is a beginning of awareness that location of sound can change, and, no matter where it is, we can try to locate it and respond appropriately.

The child progresses from learning to listen and respond to sound *non-verbally,* to learning to listen and produce an *appropriate vocal response*. This usually begins by associating sounds with animals, using realistic models of live animals, such as dog or cow.

Field trips are highly beneficial at this time—they provide needed experience. The children learn to mimic the animals seen at the children's zoo, e.g., sheep goes "b-a-a", cow goes "moo-oo", the kitty goes "meow-w".

This category of learning to listen and produce an appropriate vocal response includes listening to and *mimicking* words for common objects. Having already established a repetoire of association of word-sound symbols to common objects and successfully vocalizing animal noises in appropriate association, it becomes relatively easy for the child to listen to and mimic words for common objects. We show the child the ball, hold it for him, and say "ball" with considerable exaggeration, hoping that he will mimic the correct word. It is recommended that the teacher use objects common to the child's experience which have *b, p, m,* and *ch* for initial consonants.

Success is structured. The techniques of the therapist is of utmost importance—attachment of sound symbol to the common object must be structured.

The transition from *saying* words to *using* words is a big step towards attaining the goal of social language. Just mimicking words, or being stimulated to say words, is not necessarily *using* words appropriately. The earliest actual using of words is naming what is wanted. For instance, the child will say "milk" for wanting milk, or "cookie" for wanting a cookie. Naming is the first thing that we do in teaching the child to *use* words appropriately.

We move from naming, or labeling, to qualifying objects, such as the "big ball", the "little ball". Size is used as an initial qualifying term because it seems to be more readily reinforced than color and shape. The idea of size can be reinforced with the total body.

Verbs must be added to develop sentence structure. We use action pictures (mama at the washing machine) and employ the Fitzgerald Key, although actually only producing a two-word sentence (mama washes). This is expanded to "Daddy works", "Brother plays ball", "Sister studies", using the siblings' actual names. We have had considerable success in using the Language Master with the cards keyed with gerunds with pictures of activities within the realm of experiences of the children.

Good sentence structure can come from everyday conversation, using the child's own words. In addition, good conversation can evolve in dramatic play. The importance of teaching our children to be good TV watchers cannot be overstressed. Television is one of the best discussion starters in the morning with our older children. It is within their experience. Though TV may not be the most desirable experience, it does exist; and we might as well capitalize on it. The use of music cannot be discounted. Many first words occur during music time.

Suitability of materials should be determined by a definite criteria:

1. Materials should be motorically corrected. In a language demanding situation, a child should not be challenged to manipulate a toy or device he is not yet able to handle with assured success, e.g., stacking, nesting, windups, using scissors, drawing a circle. The therapist must know the child's level of eye-hand coordination.
2. Material should be within the child's area of social interest. This should be carefully observed in role playing.
3. Materials, common objects, animals, pictures, should be selected within the realm of the child's own experience.
4. Materials should be useful ultimately.

No discussion of techniques and procedures is meaningful without considering the kind of person who is using these techniques and procedures. Being knowledgeable in language therapy is not enough. The example or behavior pattern set by the teacher, or therapist, is the key to progress in language skills. Kindness, the anticipating smile and gesture, the light touch or the firm touch, consistency, clarity, a complete feeling of involvement with the child and activity, the shared joy of accomplishment, and knowledge combine to produce an effective change in language behavior.

It also should be observed that the use of non-professional workers in the development of communication skills for the mentally retarded has been explored in recent years. The use of volunteers, ward aids, and parents as shapers of communication have been used effectively (Witt and Witt, 1966; Molloy and Witt, 1967).

## Summary

Therapy for the development of communication skills in retarded children is based upon perceptual training. The course proceeds through defined steps:

1. Learning to listen through attention compelling stimulation.
2. Learning to listen and reacting to sound.
3. Learning to listen and responding to sound.
4. Learning to listen and producing appropriate vocal responses.

The acquisition of good, usable language skill is the goal.

## REFERENCES

Strazzulla, Millicent, and Karlin, I. W. Speech and language problems of mentally retarded children. *Journal of Speech and Hearing Disorders*, 17: 286-294, 1952.

Molloy, Julia S. and Witt, Byrn. *Communication Shaping Program*. A manual for ward personnel to develop communication skills in severely retarded individuals (In preparation).

Witt, Barbara and Witt, Byrn. Home program for the development of speech and language in mentally retarded preschool children. Unpublished paper presented at the Nineteenth Annual Meeting of the American Association on Mental Deficiency, Chicago, 1966.

# DEVELOPMENTAL SCALE FOR LANGUAGE LEVELS

The developmental scale listed below is intended to provide the teacher with standardized information regarding receptive and expressive language development in the normal child. It is based on the research findings of various authorities on child development and linguistics, e.g., Terman and Merrill (1937); Gessell (1940, 1945); Doll (1947); Stutsman (1948); Metraux (1950); Templin (1952); and McCarthy (1954).

The developmental scale should not be interpreted rigidly when considering the language development of retarded children. In other words, the teacher should not compare language development between normal and retarded children with equal mental ages.

In addition, the teacher needs to view language development as following a pattern. Thus, he must guide the child through each step from receptive to expressive language. After having decided upon a starting point, the teacher must guard against forcing the child to progress as rapidly as does the normal child.

## Developmental Scale

| *RECEPTIVE LANGUAGE* | | *EXPRESSIVE LANGUAGE* |
|---|---|---|
| Turns to sound of bell without seeing it. | *6 months* | Crows, laughs, makes sounds for pleasure. Imitates sounds — babbling |
| | *7 months* | Puts two sounds together, like "mama", "bye-bye" |
| Responds to "bye-bye" by waving "bye-bye" | *8 months* | |
| | *10 months* | Makes sounds during play |
| Adjusts to commands; knows what "come here", "no", "don't touch" means | *11 months* | Says one word to name or describe something—like "mama", "water", "bye". |
| Responds to "no", "don't touch" | *12 months* | Two word speaking vocabulary |
| | *15 months* | Uses "jargon" and gestures (Jargon is his own make up language; likes talking to toys) |
| Points to nose, eyes, hair | *18 months* | One word responses include naming, exclamations and greetings. Half of vocabulary is names in speech. Uses initial vowels, consonants (says first sounds of words). |

| Receptive Language | | Expressive Language |
|---|---|---|
| | *2 years* | |
| Can point to four parts of body when given the name; can point to a few objects by name | | One third of words are nouns |
| Obey simple commands “Give me” “Put spoon in cup” | | Sentence length 2-3 words; asks to go to toilet by verbal or gesture indication |
| Can repeat from memory, 4 words | | Uses “I, you, me” fairly well |
| Can fill in words or phrases of poems or songs | | Refers to self by name. Can tell what just happened. |
| | *2½ years* | |
| Can tell what you cook on, what you sit on, what is good to eat. | | Naming objects |
| | | Three-word simple sentences |
| Child is able to “put one block on paper” | | Vocabulary consists of ¼ nouns, ¼ verbs and pronouns |
| Repeat two numbers | | |
| Can point to more objects by name | | Use of “I” in reference to self |
| Can name something in picture | | |
| Can tell you what burns, what barks, what blows. | | |
| Can give the objects of six actions as what flies, sleeps, bites, scratches, swims. | | |
| | *3 years* | |
| | | Uses 3-4 word sentences |
| Repeats 3 numbers | | Can tell what happened in more detail |
| Responds to prepositions<br>“put the ball on the chair”<br>“put the box under the table” | | Adjectives, adverbs, pronouns, conjunctions, increasing in use. |
| Can give the use of common objects, i.e. “What do we do with the spoon”?—Answer: “eat” | | When looking at picture book, the child will answer when asked, “What is he doing?” |
| | | Articulation: Consonants mastered by b,p,m, |
| | | He knows songs and rhymes |
| | *3½ years* | |
| Obeys simple commands “Put the book on the table” | | |
| Names more things—pictures | | Sentence length 4-5 words |
| Can name more things; When asked, “What do you use to . . .” (like lock the door) Can give good answer. | | Better use of pronouns |
| | | Articulation: Consonants mastered: w,h, |
| | *4 years* | |
| Can tell what is happening in picture | | Sentence length 4-5 words |
| | | Pronouns, prepositions, conjunctions, are in good use |

|  | Receptive Language | Expressive Language |
|---|---|---|
|  | Memory for sentences: "We are going to buy some candy for mother" | Articulation: Consonants mastered: d,t,g,k,. |
|  |  | Compound and complex sentences begin to appear |
|  | Responds appropriately with gesture and words to "What do you do when you are thirsty, sleepy, hungry?" | Future and past tense in common use |
|  | The child carries out requests with four prepositions (in, out, beside, behind, beside, under, in front of) | Counts three objects |
| *4½ years* | Repeats four numbers | Parts of speech: 19% nouns, 25% verbs, 15% adjectives, 21% pronouns, 7% ad-Par |
|  | Can follow three commands in order; carries out complex orders in three parts | Consonant: production 90% or more correct |
|  |  | Consonant sounds mastered: n, ing, |
|  | Knows some things that are opposite; like "brother is a boy, sister is a girl". | Sentence length 4-5 words |
| *5 years* | Can give a good answer: "What is a ball?" | Picks out and names red, yellow, blue, green. |
|  | Memory for sentences; can repeat a sentence of about 7 words. | Sentence length 4-5 words |
|  |  | Can tell story correctly |
|  |  | Can tell about things and action in picture |
|  |  | Can name following coins: penny, nickel, dime. |
|  |  | Articulation: masters consonants f, and v. |
| *6 years* | Vocabulary: can tell what several words mean | Tells more about picture; responds to picture. |
|  |  | Average sentence length 6-7 words. |
|  | Child knows the difference between a.m. and p.m. and answers questions "When does afternoon begin?" | Says numbers up to thirties. |
| *6½ years* |  | Articulation: voiced l, th. |
| *7 years* | Repeats five numbers | Girls' speech is quite grown up. |
|  | Similarities: "In what way are.... and .... alike? |  |
|  | Can tell what is silly about something |  |

| | | |
|---|---|---|
| | *7½ years* | Mastered consonant sounds: s,z.r, sh, ch, and consonant blends such as bl, dr, tr, |
| Can tell why some things are alike and some things are different<br>Remembers points of a story; can tell why some things happen such as "what makes a sail boat move?" | *8 years* | Boy's speech is quite grown up. |

## REFERENCES

Cattell, Psyche. *Measurement of Intelligence of Infants and Young Children.* New York: Psychological Corporation, 1940.

Doll, Edgar A. *Vineland Social Maturity Scale.* Minneapolis, Minnesota: Educational Test Bureau, 1947.

Gessell, Arnold L. *Developmental Schedules.* New York: Psychological Corporation, 1945.

Gessell, A., Halverson, H. M., Thompson, H., Alg, F. L., Castner, B. M., Ames, L. B., and Amatruda, C. S. *The First Five Years of Life: A Guide to the Study of the Preschool Child.* New York: Harper Brothers, 1940.

McCarthy, Dorothea. Language development in children. In: Carmichael, L. (ed.) *Manual of Child Psychology.* New York: John Wiley, 1954, pp. 492-631.

Metraux, R. W. Speech profiles of the preschool child 18-54 months. *Journal of Speech and Hearing Disorders,* 15: 15-53, 1950.

Terman, Lewis and Merrill, Maud. *Measuring Intelligence.* Cambridge, Massachusetts: Houghton Mifflin Company, 1937.

Stutsman, Rachel, *Mental Measurement of Preschool Children.* New York: World Book, 1948, pp. 139-162.

# SPEECH, LANGUAGE, AND HEARING PROGRAM: PURPOSE AND TECHNIQUES

William Gorham, M.S.

The need for speech, language, and hearing programs among people with average or above average intelligence has been long recognizd. The need for this type of service among the mentally retarded is a rather recent innovation.

The incidence of speech and hearing disorders among the normal population varies from study to study, but, generally speaking, approximately 4 to 5 percent have speech defects and 2 to 3 percent have hearing disorders. Many studies have been conducted during the past ten years regarding incidence of speech and hearing disorders among the mentally retarded. Again, results vary greatly, depending upon such factors as the nature and size of the retarded sample, type of institution, and length of institutionalization. It is difficult to derive a generalized approximation for this population. One thing is certain, however: the incidence of speech and hearing handicaps among the mentally retarded is significantly greater than among a normal population. To illustrate, the Dixon State School conducted a speech and hearing survey of its population in 1962 and found 91 percent to be speech defective and 47 percent to have hearing losses (Rittmanic, 1966).

The purpose of this paper is to offer a brief discussion of major types of speech, language, and hearing disorders encountered among the mentally retarded, types of therapy employed, and techniques which can be used by nonclinicians.

## Disorders and Therapy

Major types of speech, language, and hearing disorders are as follows:

I. Major Types of Speech and Language Disorders
    A. Articulation Disorders
    B. Voice Disorders
        1. Quality
        2. Pitch
        3. Intensity
    C. Rhythm Disorders
        1. Stuttering
        2. Cluttering

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- D. Rate Disorders
  - 1. Too fast
  - 2. Too slow
  - 3. Monotoned
- E. Language Disorders
  - 1. Language delay
  - 2. Aphasia
  - 3. Multi-lingual background disorders

II. Major Types of Hearing Disorders

- A. Conductive hearing loss-outer and middle ear
- B. Sensori-neural hearing loss-inner ear and retro-cochlear
- C. Mixed hearing loss

Major types of speech, language, and hearing therapy are:

I. Major Types of Speech and Language Therapy

- A. Articulation
- B. Voice
- C. Rhythm
- D. Rate
- E. Language development
- F. Language improvement
- G. Aphasia therapy
- H. Communications development
- I. Foreign dialect

II. Major Types of Hearing Therapy

- A. Auditory training
- B. Speech reading (lip reading)
- C. Hearing aid training

It should be pointed out that these are the major types of disorders and therapies found or utilized with the mentally retarded at the Dixon State School. There are others, but they are of minor significance for the population under consideration.

Major types of hearing losses are conductive, sensori-neural, and mixed. Conductive losses, located in the outer or middle ear, usually can be helped by medication or ear surgery because the nerve function is still intact. Sensori-neural losses, located in the inner ear or retro-cochlear are usually irreversible if the nerve function has been destroyed. People with this type of loss, if it affects their communicative efficiency appreciably, require hearing therapy. Mixed losses contain an element of both conductive and sensori-neural impairment. If significant, they can be helped by medication, surgery, or hearing therapy, depending on the individual case.

### Procedures for the Nonclinician

Now, let us consider ways in which you, a nonclinician, can help when speech, language, and hearing problems exist among the retarded. First, be aware of the type of problem that exists. Second, know which types need professional attention and what referral sources are available. Third, know which disorders can be helped by regular staff and how they may be helped.

The task of determining which individuals can be helped and which can not is a difficult one. Generally speaking, there are only three types of therapy that will be of benefit to the severely and profoundly retarded: (1) language development and stimulation, (2) hearing aid and auditory training, and (3) medical treatment. Retardates with conductive hearing losses, cleft palate or lip, dental abnormalities, and similar disorders might be helped by medical treatment even though speech or hearing therapy has been unsuccessful.

There are two types of problems that you can work with in your residential home or school: (1) language stimulation and (2) proper use of hearing aids. All other problems should be referred to appropriate agencies.

*Language stimulation*

Language stimulation can be done by everyone. If you work with young children who have yet to develop language, the following procedures should prove beneficial.

Speech and eating use the same musculature. If eating habits are developed properly, speech will develop sooner and be more accurate in production. Developing acts of sucking, chewing, and swallowing propertly are of utmost importance to speech development.

Talk to the child you are feeding. Explain how you want him to suck, chew, and swallow his food. Tell him it will help develop good speech. Then, just talk in general.

Feeding time is a very satisfactory time for anyone. We are in a receptive, happy mood. Talking can be of great benefit. Face the child directly as you feed; sit him up as straight as possible. These procedures will help develop a good interpersonal relationship and make sucking, chewing, and swallowing more beneficial. Feed the child from the center of the mouth, and encourage good lip movement which will assist later development of the "P," "B," "M," "W" consonant sounds.

When sucking is required, see that it is done properly and firmly:

sucking slowly but steadily in corrdination with the inspiration-expiration breathing cycle. Sucking develops the "T," "D," "N," "L," "R," "S," "Z," "SH," "CH," "J" consonants.

If chewing is needed, give the child time to enjoy this activity. Encourage its forcefulness. Proper use of teeth, tongue, and jaws assists in developing various positions necessary for vowel formation and strengthens development of the previously listed consonant sounds (e. g., "T," "D").

Swallowing should be encouraged *after* the above steps have taken place. If there is trouble, a slight upward stroke of the throat or slight pressure will help. Swallowing develops the "K," "G," "NG" sounds and assists in making final sound production.

The older mentally retarded also can benefit from language development. First, keep in mind that many of them can never learn to speak normally due to their level of retardation and/or reduced control of speech mechanisms. Treat each person separately. See how far each one can advance. Some will never learn to talk, but they can improve their understanding. Others can develop a meager, single-word vocabulary. Some will show drastic improvement in expressive language.

Begin working with simple words (monosyllabic, if possible) and nouns using these sounds: "P," "B," "M," "W,"; "T," "D," "K," "G," "N,"; "F," "V." Gradually add simple action verbs followed by adjectives, adverbs, articles, prepositions, and conjunctions. These procedures will stimulate expressive longuage. Remember to show examples of what you're teaching, and keep training periods short and stimulating.

When not engaged in expressive activities, talk to the person as much as possible in clear sentences to develop receptive ability. Remember, repetition appears to be a must for the mentally retarded person, but games used or ideas incorporated should be varied, interesting, and stimulating. When words have been learned, reinforce them in as many different situations as you can, e.g., include them in your general conversation. Encourage the retardate to repeat these words as you use them.

*Proper use of hearing aids*

Retardates with hearing losses do benefit from hearing aids, but they need continual assistance in the proper utilization of these instruments. The clinic that recommended the aid, the hearing aid dealer who provided it, or member of the Department of Mental Health Speech and Hearing Program would be happy to help you in this area.

Proper use of hearing aids involves encouraging the person to wear his aid as much as possible. See that the hearing aid is put on properly and tuned to a comfortable level of loudness at the start of the day, and make sure that it is removed, turned off, and stored correctly in a box or drawer at night. A supply of batteries should be available at all times.

Check the aid weekly to see if it is running properly. Know the nearest hearing aid supplier who can furnish batteries, cords, receiver buttons, shoulder straps, and other required equipment for the specific model hearing aid being used. Also, know the nearest hearing aid dealer who can repair that particular model.

## Available Assistance

Programs have expanded rapidly in the past few years within the Department of Mental Health, and speech and hearing staff are available throughout the State to serve you. The Division of Services for Crippled Children and the Division of Vocational Rehabilitation now accept referrals for financial assistance in the procurement of speech, language, and hearing testing or therapy, as well as for the acquisition of hearing aids, dental prostheses, and cleft palate prostheses for the mentally retarded.

I hope this short presentation has provided you with increased knowledge regarding speech and hearing needs, programs, and techniques for the mentally retarded. Speech, language, and hearing are essential to the well-being of everyone.

## REFERENCES

Rittmanic, P. A. A State-wide speech and hearing program for the mentally retarded and mentall ill. *Asha,* 8(5): 182-187, 1966.

# THE PRESCHOOL RETARDATE: GROWTH AND DEVELOPMENT THROUGH ARTS AND CRAFTS

Ronald J. Berchert, M.A.

Although the pre-school retarded child has many special needs and characteristics of his own, a knowledge of normal child development from infancy to preschool age is essential in understanding the needs and characteristics of the retarded child, for in many respects, little difference exists. And, a knowledge of the developmental patterns in the preschool retardate is necessary in order to understand the values of arts and crafts for such a child.

### Needs and Characteristics of the Infant

The physical needs of the child are dependent upon the adult for satisfaction. These physical needs are largely taken care of by the parents. In addition to physical necessities, the adult must perform another important task of meeting the child's need for safety and security. As human needs exist in a hierarchy, only after the most basic ones are met can the child begin to respond to the love and affection from which he develops a self-concept and social awareness. The child's development of a healthy social response is dependent upon a consistency of treatment and patience in the handling, cuddling, holding, and rocking, which he should receive in a stable one-to-one relationship. Through this consistency of parental love, affection, guidance and training, the child matures.

Parents should make verbal responses to the child, thus enabling him to develop in the area of language skills. Although the child's response may not be initially verbal, such response will develop as the child grows. In accepting the child as he begins to move about and develop the large muscles, the parent should give the child a safe environment in which to explore, with patience and encouragement, as he begins to attempt things for himself. Many opportunities for learning should be offered him. Outdoor play, simple and clear routines with limited choices, and a genuine interest from adults are essential to his healthy development and growth.

One of the most important things we must remember is that the world around the child consists of constantly evolving experiences

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which may be pleasing, surprising, and sometimes frightening. The "self" is one of the most important things to the child and the preservation of this "self" is one of the chief motivating factors in any pre-school child. The pre-school child is a unique individual and different in his own way from other children in the group.

As the child develops from an asocial being to a social one, he becomes aware of the principal figures in his environment. With strangers, he will usually withdraw and look for security in the mother figure. The child may become startled and disturbed by sudden movements and loud sounds or voices. Gradually, the child will begin to socialize when he is beginning to play and talk with others. Although the child responds to others, he likes to be near his mother and to hear her familiar voice. The child usually wants his mother to do things for him and to play with him. As he grows and develops, he will begin to enjoy his father and become less attached to his mother. The reverse is true of the female child.

### Developmental Patterns of the Preschool Retardd Child

The retarded pre-schooler is many times unable to play cooperatively with other children and can become angry and frustrated without the guidance and affection the parents provide. Through selective behavioral reinforcement, the child will gradually learn what is acceptable behavior and what is not. It will become easier for him to comprehend his environment as a result of the patience and understanding his parents provide, as well as the necessary limits and restraints imposed upon him by a realistic social awareness. Activities become increasingly important to him at this point, since he is capable of periods of quiet play.

With most pre-schoolers, motor activity pervades all types of activities. The physical development of children is a continual neuromuscular maturation. Muscular control proceeds from the head downward, with the control being gained first in the area of eye movements, swallowing, smiling, etc., before control of the legs. The child gradually develops some motor control from experimentation with random movements which slowly evolve into the ability to grasp small objects.

The child, during waking moments, is in almost constant motion. He is exploring his environment by pushing, pulling, climbing, and dragging everything within reach. He learns by touching, feeling, and putting objects into his mouth. Due to his distractibility and response to almost every stimulus, the child has a very short attention span.

Motor skills begin to develop along with the physical growth of the child. A marked change takes place in the child; he is developing muscle coordination, but small muscles have not yet begun to develop. The child needs more periods of rest because he fatigues easily as his motor skills are developing.

Eye-hand coordination begins to improve as the child makes increasing use of his hands. The child's level of activity is high with still a very short attention span. The attention span begins to widen as the child's physical development increases. Now, as the child finds he is able to do some things for himself, his world becomes even larger and more interesting! Gradually, he acquires the ability to do things that require even greater skills and muscle control. Constructive arts and crafts will enable the pre-schooler to utilize this predominant motor activity and find satisfaction in reaching new levels of motor control.

### Growth and Development Through Art

Art experiences can assist the child in attaining an awareness of self, in formulating new ideas, and in expressing his feelings and emotions effectively. Initially, the child begins to draw with random motions or "scribbling" which, like babbling is a primitive form of expression and represents the first "paper-pencil" experimentation with this medium. This scribbling is a means of self-expression, as well as a potentially high form of creation. In fact, scribbling is a higher form of art than that which has been influenced by other personalities and social concepts of the adult world. We must remember that through scribbling, the child expresses what he sees and how he feels. Freedom of self-expression applies to all stages and all levels of creative activity. When a scribbling child is forced to express himself in an adult manner, he looses individual expression. The gratifying experience of finding oneself rests upon the development of self-expression. This development cannot be rushed without disturbing the child's natural growth process.

Many forms of arts and crafts will provide new materials and experiences in which a child can explore his abilities. These materials and experiences should be presented to the child in a sheltered setting that lends itself to a self-involvement.

Arts and crafts, by their nature, provide an opportunity to follow directions in a task-oriented setting. Following directions is very important to the further growth of a retarded child. These directions should be simple one-step procedures that a child can master easily with the guidance of an adult.

Through the medium of arts and crafts, the child may be afforded a constructive outlet for aggressive, hostile, or destructive impulses.

Such projects as finger painting, sand play, and clay work will provide such an opportunity. This type of unstructured activity permits the child to destroy his own work in a healthy fashion.

The retarded child needs an opportunity for simple repetition which can be gained through certain arts and crafts. The simplest form of repetition can be seen in the free scribbling motion of a child's art work. This repetitive motion will help the child develop muscle tone and fine muscle coordination by which he can progress to new levels of physical development.

As the child becomes more aware of "self" and objects around him, his drawings will change from scribbling to symbolic representations. When a child reaches the stage of symbolic representation, he should be exposed to more experiences in his environment (e.g., plants, flowers, trees, and weeds). These experences will increase his visual knowledge of objects which he can then touch, feel, and smell.

The child may express himself through choices of colors and symbols which represent his ideas. As the child matures, symbols become more definite and a more sophisticated relationship to his environment develops. During this period of symbolic representation, the child develops an awareness of his physical body and his own independent capabilities; he begins to perceive himself as a separate entity, apart from all others.

Developmental stages in creative activity proceed at a slower rate for the mentally retarded. Any work that is prematurely forced upon the child creates tension and dissatisfaction. When a child feels unable to perform a task, he will develop a lack of confidence and feelings of inferiority. During this period, the child needs a great deal of guidance from a mother figure and the assurance that someone is watching over him. He needs an abundance of freedom in conjunction with patient guidance by teachers and others. This guidance will help the child develop self-confidence which will enable him to accomplish higher-level tasks.

## The Teacher's Role

As teachers of pre-school retarded children, the first and most important concept we must understand and accept is that all children are creative and have various levels of maturity. Children differ in the way they learn. We must search constantly for new methods and techniques in order to open doors of opportunity and continued development. For example, the teacher of retarded children can be of valuable assistance in helping children to associate their own names with their bodies. The teacher can observe the child's development of concepts by carefully observing his drawings. To illustrate: the most important thing to the pre-school child is his own body, and any drawing at this stage will mirror his body image. Teachers should observe whether the child's drawing has elaborate arms, hands, feet, etc., or whether such details consist only of a few lines representing arms and legs. The drawing will enable the teacher to ascertain the maturity of the child's self-concept and serve as guidance in offering new activities.

As teachers, we should have children begin with large, free motion and use simple tools and materials. This approach will enable us to expand the child's world and to give him new, more complex experiences as he is ready to cope with them. Simple tools should involve use of the large muscle skills.

As the child progresses, the teacher may introduce activities which use small muscle skills, such as crayon rubbings, simple painting and clay work. The teacher, through careful and empathetic guidance, should encourage the child to experiment with tools, materials, and processes which develop coordination and muscle control.

Art work of the pre-school retarded child should be judged on the basis of the new experiences it provides, rather than the products. A child can achieve new insights into his work only if it is accepted for what it is. We must not forget that a child has the right to make mistakes in exploring his world for the first time. (Rigid adherence to reality is the surest way to squelch creative efforts in retarded children.) Displaying the child's art work will help motivate him to attempt new and more difficult tasks. Thus, stimulation of these children in new and varied ways, through their perceptual environment, is essential to maintaining an active interest in creative activity.

The child can do many things with the guidance of adults, but must not become too dependent upon their decisions. We, as adults, must not be overprotective. Many times, if a child is allowed to make his on decisions, he will make them with little assistance from the adult.

Careful planning and selection of arts and crafts projects is of major concern to teachers developing a reinforcing and satisfying growth program for their children. Properly used, arts and crafts can be one of the most valuable growth experiences for the retarded pre-schooler. They may be used to enhance the pre-schooler's perceptual acuity, to help him explore his environment, to aid him in testing reality, to further develop motor coordination, and to assist him in establishing a healthy relationship to his environment.

# MUSIC ACTIVITIES FOR THE SEVERELY MENTALLY RETARDED AND PRESCHOOL MENTALLY RETARDED

Eleanor Lesak, R.M.T.

The use of music in meeting the needs of the mentally retarded child has expanded greatly in recent years. Even the most limited children can profit greatly from a skillfully planned and presented music program.

## Goals and Objectives

The goals of a music program in a day care center parallel the overall goals of special education: helping each child become an "adequately adjusted person, socially acceptable at home, in school, in the community or institution, capable of self-care, occupying leisure time purposefully, and being economically useful at home, school, in a sheltered workshop or residential setting" (Molloy, 1963).

The severely retarded, as well as the pre-school child, is often non-verbal. Music, because it offers a sub-verbal means of communication, can become a means of establishing the contact so necessary in initiating an interpersonal relationship.

The small child, newly separated from home and mother is comforted and reassured by hearing a familiar nursery rhyme or melody when he enters the strange new world of "school". Gaston (1958) has stated that music is closely related to tender feelings and that "the arousal of love is important and essential because it helps provide feelings of security. . . ." The youngster greeted with regularity in this way begins to feel secure in this structured and predicatable situation.

## Curricular Suggestions and Techniques

Moving from an introductory situation to a more closely structured one is often a difficult time. The ringing of a small "school bell" accompanied by a softly sung—"Time for school, time for school, ding-dong, it's time for school"—soon becomes a pleasant signal that the "down to business time" of the day is about to begin. (A similar device may be used for lunch time, nap time, and the similar.)

Closely structured periods may be motivated and encouraged by the introduction of music activities into the regular learning session. For the young child, brief and varied experiences such as finger plays,

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singing games and action songs should be a part of their daily program. These experiences enhance auditory training as well as offer opportunities for motor development. For example: with the teacher and children seated around a low table, the teacher demonstrates first by placing both hands with palms up upon the table. She sings softly:

> "Open shut them, open shut them, give a little clap
> Open shut them, open shut them, lay them in your lap."

As she sings, she moves quietly and appropriately. Next, she smilingly suggests, "Let us all try it." An approving pat or glance to the acceding child is important at this point, but no disapproval nor attempt to force the laggard to comply. Daily repitition, and an encouraging, positive and expectant attitude usually guide the group into some degree of response.

Since any degree of participation is acceptable, even the minimal response of the most severely retarded has the effect of making him a participant in a group activity, socialization thus becomes a constant by-product of group music activities.

Body concept and the identification of body parts can be promoted by the use of action songs which require the participant to move or touch various parts of his body. An auditory response is not elicited (often it comes anyway). Only responses indicating that the child is listening and watching are needed.

A wide variety of material has become available for this purpose. A fine example is "Songs from Singing Fun", which is available for the piano and on recordings. (*I Wiggle My Fingers* and *Two Little Hands* are especially good for presentation to small groups). The children should be seated in low chairs (feet touching the floor). The teacher faces the group also seated on a low chair. Active participation by the teacher is essential since observation and imitation initiate the activity at this point. Listening and watching the appropriate movements, with frequent repitition and stimulated by lively melody and rhythm, responses may be feeble at first, but gradually concepts develop in relation to the ability of the child and responses strengthen.

Isern (1960) has stated that the severely retarded respond with greatest success to the element of rhythm in music. Even those with the lowest mental age respond in some way. As an example, let us describe the presentation of rhythmic activities which proceed the handling of rhythm instruments. Here, too, children should be seated in low chairs (feet touching the floor). The teacher faces the group, also seated on a low chair, so that she is not towering over the children—she is one of them.

The following steps are suggested:

1. "Let us all *listen* (to music with a strong, simple rhythmic beat 2/4 or 4/4 tempo)".
2. "Let us all *clap* our hands to the music."
3. "Let us all *tap* our toes to the music."
4. Show the children a bell or shaker that can be used with one hand, or wrist bells that need not be held. Demonstrate use by shaking rhythmically or by tapping into the palm of the other hand.
5. Offer each child the same instrument. If he refuses to hold it, simply pass him by pleasantly, without comment.
6. Let them play and "make music" for themselves.
7. "Now let us all play together", and all "play" to the music, including the teacher.
8. Quickly gather up the instruments into a small basket or box before the children lose interest in them.
    a. One day the teacher says, "Today I will not play what you play. I will be the leader and only wave a baton. Later you may be the leader and I will take your place." Teacher changes places with each child in turn (this is a strong reason why the beginners group must be small).
    b. Introduce new instruments, e.g., jingle bells, bells on handles, tambourines, rhythm sticks and triangles. Do not introduce too many on the same day.
    c. Then comes the day when the teacher can say: "Today you may pick the instrument *you* would like to play." Place 3 or 4 different instruments on a low table. Direct each child to select one in turn, replacing the selected one with a duplicate as each makes his choice. Sometimes they will all choose the same one—sometimes not. Be sure to vary the child allowed to pick first.
    d. The most interesting development of the rhythm band is learning to respond to a clue. Simplest is the request: "Let us all hold our instruments up—up high—until the leader says play!" This becomes a game, with the part of the leader in great demand. Variety may be introduced by permitting the leader to pick the "next leader", exchanging places with him.

Response to a musical clue by the leader and the band may be effected by the use of an interlude or special series of tones that say "Up" and "Play" to one and all (Lesak, 1963).

These repetitive and structured steps allow many responses acceptable as a group activity or individually as indicated. Success is attained easily and quickly through a fun-filled activity, which requires self-control, group, experiences, the extension of attention, and good listening habits.

Well-structured, frequently repeated music activities help to establish a feeling of order which creates, in turn, a sensation of inner-order and lessen turmoil and anxiety. Music time should always be associated with enjoyment. The attitude of the teacher must be consistently one of encouragement. Enjoyment in what she is doing must be obvious and sincere. Often, this is an extension of personality, but it also should be considered a deliberate device to obtain a desired result.

As the children grow in age, in interest level, and in ability, music may be used as a tool for learning. Scheerenberber (1953) described an institutional music program in which songs were selected on the basis of interest, enjoyment, and curriculum correlation. Songs of family unity, love of country and of God, the seasons, the weather, good manners and safety are long remembered and easily recalled. The control needed to respond to verbal directions. musical and rhythmic clues may be obtained through group singing, the rhythm band and simple folk or square dances. Physical, mental, and emotional handicaps are often overcome by eagerness to participate in these activities. The very words, "music", "sing", and "dance" arouse an image of joyous activity, bringing to the music program rehabilitative values not present in other areas (Lesak, 1963).

Juliette Alvin (1959) of London, England, in her touching account of a musical experiment with retarded children, noted that:

> "When a child's interest and curiosity are aroused, he is in the best condition to perceive and absorb . . . all children have a sense of beauty although it may not be an adult's sense of beauty . . . music can open a new world of emotional and intellectual activity to those handicapped children whose lives are deprived of many fine experiences because of the innate poverty of their minds".

The semantics may be strange to us, but surely the point is well made.

Spiritual and aesthetic development in retarded children, an area not often explored, can be encouraged by familiarity with good music. The creative satisfaction of making music or of dancing brings an appreciation of beauty. For these children, their development can be measured best by their joy of participation, happiness in achievement, and the glow of wonder seen in the eyes too often dull and unattending.

## REFERENCES

Alvin. Juliette. The response of severely retarded children to music. *American Journal of Mental Deficiency*. 63: 988-996. 1959.

Gaston. E. Thayer. Functional music. In: Nelson. H. (ed.). *Basic Concepts in Music Education*. Chicago: University of Chicago Press. 1958. p. 302.

Isern. Betty. Summary. conclusions and implications: The influence of music upon the memory of mentally retarded children. In: Schneider. E., (ed.) *Music Therapy*. Lawrence. Kansas: University of Kansas, 1961, 149-153.

Lesak. Eleanor. Music for trainable children. In: Molloy. J. S. *Trainable Children: Curriculum and Procedures*. New York: John Day, 1963. 34-35.

Molloy. Julia S. *Trainable Children: Curriculum and Procedures*. New York: John Day. 1963.

Scheerenberger. R. C. Description of a music program at a residential school for mentally handicapped. *American Journal of Mental Deficiency*. 57:573-579. 1953.

# ACTIVITY PROGRAMS

Nancy Schuler

A person engaged in a constructive activity usually looks and feels well. Subsequently, there is a greater tendency for him to conduct himself in a normal or near normal manner. It has been demonstrated on numerous occasions that individuals who become personally involved with many phases of living are happier, more content, and reasonably self-assured.

To motivate and to assist the retarded in utilizing advantageously whatever ability lies within him is a most rewarding endeavor. To help the retarded person realize his potential, possibly after many years of failure and disappointment, and to bring about or restore his faith in himself and in his ability is one of your major challenges.

The term "activities", for the sake of the present discussion, is used in a broad sense, and not limited to handicrafts. One should think of activities for the retarded in light of education and personal development, both mental and physical. It also is well to remember that the temperaments and personalities of all people, including the retarded, tend to differ widely, and that the key to success is in bringing people and activities together in a right combination.

Many of the adult retarded placed in proprietary homes from the large state institutions have had work and activity experiences. *Each retarded should be interviewed* to discover what he had done in the institution. Activities may be begun at a higher level if the individual has had certain experiences. For example, many of the women have operated sewing machines or done fancy work. Both men and women may have assisted in kitchens, dining rooms, child care and infirmary areas, clothing rooms, and the laundry. They may have operated weaving looms, done furniture repair, and worked as messengers, store assistants, trucking assistants, housekeepers, farmers, and gardeners.

The index for activities often follows the previous orientation; some retardates will benefit more by utilizing former skills than by struggling to learn totally different skills. A well-rounded program of *real living* takes into consideration the background, education, ability, and physical condition of each individual.

Most activities—manual, recreational, and educational—can be broken down (simplified) or built up (amplified) to meet the needs and abilities of the individual. A few familiar activities will illustrate this process.

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| *Activity* | *Simple* | *to* | *Complex* |
|---|---|---|---|
| Needlecraft | Sewing cards<br>Hemming<br>Sewing buttons | Making aprons, baby bibs, simple skirts headscarves. | Dressmaking from multiple piece patterns. |
| (Embroidery) | Gingham cross-stitch (borders on light or dark squares). | Square counted cross-stitch | Pattern cross- stitch (following a printed pattern independently). |
| Ceramics | Hand-formed or "squeeze" objects, rolled cut-outs, press-molds, simple glaze decorations. | Mold-formed ceramics from liquid clay. Stencil or impressed decoration. Coiled and slab hand forms. | Wheel-formed pottery, free-hand decoration, underglazing, overglazing, stains. |
| Carpentry | Cutting simple shapes with hand saw, sanding, applying finish Plaques, simple glued boxes, trays, bookends, desk accessories. | Simple joints, nailing and use of screws. Shelves, picture frame construction, etc. Repairs to furniture, simple household fixtures. | Furniture construction. Measuring, rearing patterns, using power tools. |
| Gardening | Watering plants, planting seed (using uniform measures to insure proper amounts and correct spacing). Raking leaves, pushing barrow, hand-mowing, gardener's assistant. | Spading garden, raking and planting, cultivating large plants. Wood recognition. Indoor plant culture using hardy plant varieties. | Planning and laying out garden, planting, cultivating, harvesting. Knowledge of pests and control. Fertilizing. Dish gardening and miniatures. Flower arranging. |
| Puzzles | Five-piece wood puzzles, related to everyday known objects. | Multiple-piece puzzle, depicting known objects and situations, clear color structure. | 300- to 1000-piece jigsaw puzzles |

Once you have become accustomed to thinking of activities in terms of complexity and required skills, you will be able to analyze other tasks according to their essential components.

Sometimes an activity has distinct phases or operations which can be done by several people as a group activity. For example, in making stuffed toys, some of your patients could trace the pattern, some could cut out the various pieces, some could sew and embroider, and some could insert the stuffing. Several of these operations require more ability and skill than others. Thus, a group of people with varying degrees of ability could work together and produce a satisfactory product. At the same time, and of equal importance, the retarded would learn the value of one person assisting another to accomplish a task. This technique often works well with those retarded who are able to learn one phase of an activity to perfection, but has difficulty in working with several different phases at the same time. Each retardate should be aware, however, that he is but one member of an active team. He also should know that his part in the activity is important and vital to the total effort.

While the staff should be interested in the affairs of all residents, it is advisable to employ an activities director, either on a part-time or full-time basis, to insure the development of a successful program. Such a person could assume a variety of responsibilities, including recruiting and training volunteers, preparation of materials, collecting donations, soliciting supplies and equipment, and devising methods of maintaining the program. The director should have a demonstrated organizational ability; an aptitude for handicrafts and other manual skills; the ability to adapt skills and materials; adequate skill in public relations; and finally, and of utmost importance, a tolerance and appreciation for the retarded.

# RECREATION

Mary Downey

A proprietary home without a well-planned recreation program is a dull, lifeless environment. Recreational activities, meaningfully and understandingly presented by a motivated and trained leader, become a creative, stimulating life experience for the retarded.

A recreation program can include a host of activities ranging from basic self-help skill classes to social clubs. Self-help classes provide an opportunity for the retardate to acquire the desired skills and habits relative to such activities as good grooming, telling time, using laundromats, and making change. Such programs also assist the retardate in learning to follow directions and accept discipline.

It is also important that the retardate develop motor and muscular coordination, as well as good physical fitness, if he is to function satisfactorily in his environment. Recreation can be of considerable value in this area through such activities as organized games, dancing, volleyball, relay races, and physical fitness groups.

Language development, which is always essential, can be an integral part of a recreational program. Singing songs, musical games, following related directions, and associating actions with verbal commands are very effective. All retarded patients, regardless of their levels of language development, should be exposed to new sights and sounds and be drawn into spontaneous talkative groups. Even though a retardate may not speak, if he has learned to listen and understand, he has made considerable progress.

## Suggested Recreational Activities

Though it would be impossible to discuss in detail the entire range of recreational activities that can be offered to the retarded, a few general areas and illustrative examples may be of assistance.

### AUDIO VISUAL AIDS

Television
Radio
Record Player—Records
Flash Cards
Bulletin Boards
Reading
Flannel Boards

Example: The audio-visual area is designed to supplement the planned activity program. These aids may be used for enjoyment and relaxation during periods when no organized activities are available. These aids are also valuable as rainy day activities.

### DRAMA

Plays
Acting Out Stories
Charades
Puppets
Choral Reading
Improvisations
Tableaux and Pantomimes

Example: Tableaux and pantomimes are frequently produced with no equipment or costumes and with all types of individuals participating. Skillful acting and language development are unnecessary for the success of these activities.

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## HOBBIES AND SPECIAL INTERESTS

Flowers
Painting
Gardening
Collections
Needlework

Example: Gardening is a valuable recreational activity, for even a few days of work in the open air digging; planting and weeding help to hasten the hours of idle time. It may also provide a sense of accomplishment when the results of their work and planting occur.

## SOCIAL RECREATION

Table Games
Social Clubs
Dance Hour
Bingo Party
Movie Theaters

Example: Social Clubs fulfill many of the basic needs of the retarded resident in a proprietary home. Engaging in activities with other individuals gives a sense of security and a sense of belonging. This social contact will also aid the retardate as he prepares to join larger groups and enter the community.

## NATURE

Nature Hikes
Cook Outs
Fishing
Scavenger Hunts
Wading Pools

Example: One of the prime objectives of interest in a nature program is that of increasing the understanding and appreciation of the world around us. Nature activities may include gathering materials for cook-outs and using native materials in a craft program. The retarded in sheltered care homes should benefit greatly from outdoor activities.

## SPECIAL EVENTS

Athletic Events
Carnivals
Zoos
Circuses
Parks
Band Concerts
Holiday Festivals
Bowling
Art Shows
Parades

Example: Special events are an important aspect of any activity program. Such events will provide a break in the long hours of routine and monotony. Trips and special events are also quite a treat for the retarded. Most important of all, trips and special events prevent the proprietary home from being isolated and becoming a small institution. Proprietary homes should be a part of the mainstream of community life.

## MUSIC

Musical Games
Dances
Choral Group
Kazoo Band
Rhythm Band
Volunteer Entertainment
Amateur or Talent Hour
Melody Bells

Example: Music affords opportunities for creativity, self expression and social interchange as well as sheer enjoyment from listening and participation. For example, a rhythm band will help fulfill the basic needs of the participants in the band, as well as providing entertainment for the other residents of the proprietary home.

## Planning and Directing a Recreational Program

Listed below are fourteen basic suggestions for directing and planning a recreation program:

1. Select a suitable game for your specific group.
2. Have a thorough knowledge of the game before you teach it.
3. Have necessary equipment ready for the game.

4. Do not waste time while organizing the group.
5. Begin play immediately. Avoid lengthy explanations and omit unessential rules.
6. Give all residents a chance to play.
7. Demonstrate the game before actual play begins.
8. Use a variety of games; do not continue a game in which the group has lost all interest.
9. Speak slowly and distinctly.
10. Be kind, but firm; always make group corrections and not individual ones. Laughter is the best corrective.
11. Don't try too many new activities at once.
12. Play the game for fun, and be an enthusiastic participant yourself.
13. Write out an outline of things you plan to do so that you may progress rapidly from one activity to another.
14. Through repetition the residents will learn to enjoy various games.

In developing and planning a recreational program, you are encouraged to utilize outside resources, such as university recreation departments and extension services, mental health zone personnel, and other agencies within the community which can offer both consultation and service. Most of these resources are most willing to be of assistance.

### Recreation Leadership

Recreation leaders are made, not born. Usually they are self-made; and the shyest person may, in time, become a competent leader, developing a new personality in the process. It takes constant preparation and throught to become a competent leader, as well as unceasing effort and desire to make others happy.

A well-planned activity program will provide benefits for young and old alike and allow residents to use their leisure time wisely. With experience, the leader will gain poise and self-confidence and learn to express himself clearly, to plan appropriate activities, and to deal effectively with the retarded.

# EDUCATIONAL EVALUATION OF THE CHILD IN A DAY CENTER FOR THE MENTALLY RETARDED

Elaine McNab Hoff

Interest in the growth and development of programs for the trainable and severely mentally retarded has increased rapidly in recent years. Public School programs have been extended to include the mentally retarded. Diagnostic services and habilitation centers sponsored by private groups have experienced a period of rapid growth. The need for reliable evaluational instruments for assessing the development of mentally retarded children and adults has been cited by virtually every investigator in the field (Cain, *et. al,* 1963).

It is a well known fact that most of the present psychometric instruments, designed for the general population, have very few items in which the moderately or severely retarded can score successfully. A review of the items performed or not performed successfully on these tests is of little value to the classroom teacher in getting a true picture of the individual's performance level as it relates to education or training (DiNola, *et al,* 1965).

The present discussion will be concerned primarily with this vital problem of evaluating training progress among the moderately and severely retarded. Also, reporting to parents will be considered.

## Goals of Evaluation

Precise evaluation of the retardate's progress in a training setting can satisfy four objectives:

1. To see if the child has learned what we tried to teach him.
2. To advise parents of their child's growth and to encourage a co-ordination of home and school training.
3. To determine whether the curriculum is appropriate.
4. To apprise the teacher of the adequacy of her techniques and to decide whether a change in methodology is indicated.

## Evaluation Scales and Report Forms

There are five commonly used scales and report forms. Each of these will be discussed briefly.

### The conventional report card and check sheet

The conventional report card and various check sheets are still

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the most widely used method of reporting a child's progress. True, we are becoming increasingly more sophisticated in the way we report progress. The "F" representing failure has been replaced by a "UP" for unsatisfactory progress. The "UP" has been replaced by "NMT" or "Needs More Time". Regardless of the initials used, the message comes through loud and clear. The child has not learned what we have tried to teach him. The reasons for the child's inability to learn may be many and varied.

In any event, a frequently overlooked, inherent danger with this type of report is the reaction of the teacher to pupil "failures". Too often, a successful pupil is interpreted to be the same as a successful teacher.

A majority of teachers react with a mixture of frustration and discouragement. For those who have sincerely and conscientiously applied the knowledge and methodology acquired through formal training and practical experience, the failure becomes that of both the child and the teacher.

Another type of reporting device is the check sheet which may include up to six evaluative statements for recording progress. A sample report approach and its associated key as recommended by Perry (1966) is presented below.

### LUNCH TIME BEHAVIOR

The key:

NC—No change; not being taught at present, or situation does not present itself at this time.
N—No (child unable to perform task)
H—Needs some adult help to complete task well.
R—Needs reminders to complete task well.
I—Independently but with adult in the same room watching.
A—Completes whole task alone even when not conscious of being observed.

Expected behavior:

1. Waits to eat until all are served.
2. Waits to take food until passed to him.
3. Takes only one cookie or tidbit each time plate is passed.
4. Takes serving plate from left, helps self, passes to right (or vice versa).
5. Talks only when no food in mouth.
6. Takes polite sized bites.
7. Chews and sips unobtrusively.
8. Keeps crumbs on table.
9. Breaks large pieces into smaller ones.
10. Spoons food neatly, no hands on it.
11. Wipes mouth and fingers effectively.
12. Stays in seat until all are finished.
13. Passes food without sampling.
14. Passes juice or milk without spilling.
15. Holds cup below edge when passing.
16. Serves each child consecutively around table.
17. Systematically clears table of paper trash.

Most teachers of normal children, with a class size of 30 to 40, would flatly refuse to spend the time required to record their pupils' progress in this detail—and well they should. For the trainable and severely mentally retarded, however, this type of reporting is necessary if any and all progress, no matter how small, is to be reported.

This degree of detail is obviously of great importance in evaluating both the program and the progress of the mentally retarded. It is only in terms of these "smaller" tasks that educational achievement can be observed and measured accurately. Thus, the conventional report card approach is inappropriate for use with trainable and severely retarded. Check sheets should be used only if the degree of detail is sufficient to present the true progress of the child.

### Anecdotal records and behavioral journals

Behavior journals are used to record the daily behavior of each child as the teacher sees it. A teacher using this type of reporting system must be very careful to record positive as well as negative behavior.

The saying, "No child is all bad", is familiar to all of us. After a particularly demanding day, however, the teacher's behavioral journal may not reflect this axiom.

Reporting, instead of merely judging, should include educational and learning difficulties as well as provide concrete suggestions for their improvement and remediation (Johnson and Lavely, 1966).

Connor (1964) recommended three kinds of individual records based on anecdotal reports. These were:

1. A rating on the child's progress with respect to curriculum items, checked at the beginning of the year, at mid-term, and at the end of the term.
2. A year-end summary of each child's progress with respect to long-term training goals.
3. A year-end report to parents, based on the individual summary. This report was the concluding phase of the year's child-parent-teacher relationship. Older children were shown their reports and had an opportunity to discuss them. Younger children were given whatever information they seemed ready to understand and use.

For each class, a comprehensive annual report, summarizing briefly the year's curriculum, including both study and classroom activities, was prepared by each teacher for their respective group. A resumé and evaluation of group progress toward long-range and short-range curriculum goals were part of the report. Information concerning progress in the various areas was drawn from anecdotal records and from the curriculum guide ratings of individual children (Connor, 1964).

Ginglend (1957) recommended still another type of reporting system, based on a dialogue description of the child's progress with respect to major areas. For example, in the area of social development and adjustment, he outlined the following:

> "In this area such things are considered as self-help, habits of health and safety, music and rhythms, taking direction, sharing and working together cooperatively with individuals and groups as well as independently, developing interests and leisure time activities, aiding him to withstand stimulation, and the development of group and free play activities."

The types of questions related to this area were as follows:

Can he do more things for himself?
Have his eating habits improved?
Does he occupy himself in play or other activity?
  on his own, more often?
Does he cooperate better?
Is he less distracted?

This type of report is journalistic in style and allows the teacher to write between the lines. The question of objectivity on the part of the observer as well as adequate coverage of the curriculum areas are major problems associated with this system. In addition, the next teacher may find the report difficult to understand. Misunderstandings also may arise when parents receive and study the report. They may read "into" the report conclusions and comments that they want to accept. The teacher may find herself saying, "Well, what I meant to say was . . . ."

## The Cain-Levine Social Competence Scale

The *Cain-Levine Social Competence Scale* was developed specifically to provide a method for measuring the social competence of trainable mentally retarded children. It consists of 44 items divided into four subscales: Self-Help, Initiative, Social Skills, and Communication.

The total scale offers the user a number of advantages. First, the percentile rank obtained for a particular child enables the evaluator to discuss with the parent or teacher the child's overall social competence, as well as his competence on the four subscales, relative to mentally retarded children of his age group. An analysis of the child's ratings by the evaluator may be helpful in discovering aspects of the child's social competence to which parents or teachers may direct their energies. Second, the scale can be of help in the selection of children for school programs, determination of placement within the program, and for assessing the children's progress. Third, results obtained from administering the scale may be used as a basis for curriculum planning.

Finally, the scale may serve as a criterion measure for research purposes to test the results of training, the relative effects of various teaching techniques, and the influence of different environmental conditions on the children's social competence (Cain and Levine, 1963).

### The Vineland Social Maturity Scale

The central purpose of each item in the *Vineland Social Maturity Scale* is to present some particular aspect of the child's ability to look after his own practical needs. The items sample such social behavior as self-sufficiency, occupational ability, communication, self-direction, and social participation and to reflect progressive freedom from need of assistance, direction, or supervision on the part of others (Doll, 1946).

The main disadvantage of this type of test is that it should be administered only by a trained psychologist.

### The TMR Performance Profile

The *TMR Performance Profile* was designed for use and administration by the classroom teacher. The major areas and related topics, as well as their respective items, were selected because they are within the limits of the abilities and experiences of the moderately and severely retarded.

The six major areas most frequently referred to in curriculum guides for the moderately and severely retarded were used as the basis of the *TMR Performance Profile*. They include: (1) social behavior; (2) self-care; (3) communication; (4) basic knowledge; (5) practical skills and (6) body usage.

Each of the six major areas is sub-divided into four related topics. For example, self-care is divided into: (1) bathroom and grooming; (2) dealing with food; (3) clothing and (4) safety.

The *TMR Performance Profile* enables the teacher to:

1. Record observations of the performance of the severely and moderately retarded pupil;
2. View these scores in a graphic form;
3. Identify the areas of need and competence for an individual or group;
4. Adapt curriculum materials and methods to meet the needs and increase the competence of the moderately and severely retarded pupil;
5. Review periodic change and development;
6. Maintain a cumulative record based upon a common frame of reference understandable to all personnel who use the TMR Performance Profile; and
7. Answer the question, How is Johnny doing?

One broad area that appears in the TMR Profile is self-care. Within this area, we evaluate the child's ability to use utensils to eat (DiNola, *et al,* 1965).

In terms of many alternative evaluative devices the teacher has a choice of "good", "fair", "poor" or "needs more time". The child who uses a spoon (but not a fork or knife) with some help, will probably receive either a rating of "poor" or "needs more time". Hence, back to where we started. Everyone feels like a failure. A more realistic approach, as used by the *TMR Performance Profile* is to distinguish between utensils—spoon, fork and knife—and then decide what developmental steps are necessary before full utilization of all utensils is achieved.

The teacher can then evaluate the step-by-step progress of the child. The child who cannot use a spoon to eat soup, may have learned to use successfully a spoon with soft, sticky foods. This step-by-step approach is detailed carefully in the *TMR Performance Profile* (DiNola, *et al,* 1965).

Another example of familiar skills found on all evaluation reports is the proper use of a scissors. A piece of paper with a heavy black line drawn across it is handed to the child.

Accompanying instructions are usually as follows: Take your scissors and cut along the black line. If the child doesn't complete the task successfully, mark him "poor". Before we evaluate the child's use of scissors, we should consider the following questions:

Can he hold the scissors correctly?
Can he open and close scissors correctly?
Can he hold the paper?
Can he cut paper not following any lines?
Can he cut along a thick straight line?
Can he cut a square?
Can he cut a diamond?
Can he cut a circle?
Can he cut a combination of above?

The task must be evaluated with this step-by-step approach if the evaluation is to present a true picture of the child's progress.

### Reporting to Parents

Assuming that we have carefully and realistically evaluated the child, we must interpret this evaluation to the child's parents. The parents of trainable and severely retarded children are painfully and emotionally aware of the child's inability to perform academic activities like other children (Ginglend, 1957). How parents accept and react to their child's inabilities is of prime importance. Some parents view the training program as glorified "baby sitting". They are not ready to understand objectively their child's limitations and abilities of the school program. They feel that school is supposed to teach only reading, writing and arithmetic. If a normal child learns to read at age six, then, their child should learn to read—maybe later, but nevertheless, he should learn to read.

Such parents should be encouraged to review their own education in terms of their adult work. Chances are, they will decide that things other than academic skills are very important (Dittman, 1959).

Because parents are emotionally involved, they are vulnerable to false hopes engendered by sympathetic teachers who resort to optimistic generalities of the child's progress. This approach is as harmful as that of the "determined realist" who speaks only of the child's inability to achieve academic material (Ginglend, 1957).

The determined realist approach generally invites hostile feelings toward the teacher. And the teacher who uses this approach must be prepared for repercussions from the parents.

Schools, and parents too, have to reject their old ideas as to the nature and purpose of special education.

Many parents know that their child can exhibit progress and growth under the right direction and training. They are justified in expecting that he have his opportunity to develop as well as any other child. They need realistic goals and some criteria in order to understand the growth and development of their children (Ginglend, 1957).

Progress cannot be determined adequately unless the teacher is acquainted with the extent of school achievement that has carried over into the home and community environment. The school's objectives should be carefully understood by the parents in order to promote cooperation between the home and school and, thereby, to lessen the possibility of conflicts. When parents accept the school's objectives, they are in a better position to support and supplement the educational programs of their children. Reports that are formulated in terms of the child's progress toward these objectives are truly informative and provide the basis for home-school cooperation (Johnson and Lavely, 1966).

## Evaluation of the Curriculum

As previously stated, one of the major functions of an adequate evaluation is to improve instruction or curricula. Every teacher needs a basis upon which to evaluate her own expenditure of energy and planning in terms of the child's growth. She needs a guide to insure that the inclusion of activities in the daily program will contribute toward the total development of the child (Ginglend, 1957). The teacher must base her instruction and program on the child's present abilities. Under these conditions, the curriculum can be used to evaluate gains and analyze failures.

A good illustration of this was provided by Wood (1960) who poses the following questions in evaluating the curriculum for trainable or severely retarded:

1. Have the children developed saleable skills and those understandings and attitudes that make the worker an intelligent and productive participant in economic life?
2. Have the children developed and maintained good physical and mental health?
3. How well do the children understand the rights and duties of citizenship in their city, state and nation?
4. Are the children socially well adjusted to family and community living?
5. Do the children know how to purchase and use essential goods and services?
6. Do the children understand enough science and its effects on man and the world to overcome fear and establish peace of mind?
7. Have the children developed to their individual capacities their ability to appreciate beauty, in literature, art, music and nature?
8. Have the children developed useful or interesting leisure time activities?
9. Have the children developed a responsibility for sharing work and pleasure with others?
10. How well have the children grown in their ability to think rationally, to express their thoughts clearly, and to listen with understanding?

The utility of criteria such as these is dependent upon the teacher's courage not to yield to pressures of those parents and school personnel who are, by tradition, oriented to the academic curriculum. Special class teachers also must be sufficiently perceptive to admit to themselves that a change in curriculum may be indicated by the child's inadequate performance or progress.

Preston's (1957) study indicates that over two-thirds of the teachers interviewed developed their own instructional program. The fulfillment of the aims and objectives of the curriculum often depended upon the ingenuity of the teachers. She states, "If teachers recognize their weaknesses and make an attempt to strengthen them, an improvement in present programs, as well as the development of a better basis for defining future programs may result."

Occasionally, a personality clash does arise between the teacher and the child. In most of these cases, it isn't possible to transfer the child to another class or facility. The teacher must carefully disguise her dislike or resentment for the child. Her subjective attitude and feelings should not be reflected in her evaluation of the child or his progress.

Teaching a child to perform adequately daily living functions to use his leisure time constructively is a very exacting and difficult skill. We must remember that the main objective of our program is to help the individual develop to his maximum potential. Effective evaluation of the child, the curriculum and the teacher can play a major role in fulfilling our educational responsibility.

## REFERENCES

Cain, Leo F., Levine, Samuel, Elzey, and Freeman. *Manual for Cain-Levine Social Competence Scale.* Palo Alto, Calif.: Consulting Psychologists Press, 1963.

Connor, Frances P., and Talbat, Mabel E. *An Experimental Curriculum for Young Mentally Retarded Children,* New York, N.Y.: Teachers College, Columbia University, 1964.

DiNola, Alfred J., Kaminsky, Bernard P., and Sternfeld, Allan E. *T.M.R. Performance Profile for the Severely and Moderately Retarded, Teachers Manual,* Ridgefield, N.J.: Reporting Service for Exceptional Children, 1965.

Dittman, Laura L. *The Mentally Retarded Child at Home,* Washington, D.C.: U.S. Government Printing Office, 1959.

Doll, Edgar A. *Vineland Social Maturity Scale, Manual of Directions,* Nashville, Tenn.: Educational Publishers, 1936.

Ginglend, David R. Some observations on evaluating the progress of severely retarded or trainable children in a school program. *American Journal of Mental Deficiency,* 62 :35-38, 1957.

Johnson, Orville and Lavely, Carolyn D. *Guidelines for the Establishment of Training Programs for Severely Mentally Retarded Children,* Albany, N.Y.: New York State Interdepartmental Health and Hospital Council, Committee on Mental Retardation, 1966.

Perry, Natalie. *Teaching the Mentally Retarded Child,* New York: Columbia University, 1966.

#SUPPORTIVE SERVICES

# PROMINENT MEDICAL CONSIDERATIONS IN MEETING THE SPECIAL NEEDS OF THE RETARDED

William B. Bradley, M.D.

This paper is intended to serve as a partial guide for persons involved in the care and training of retarded children in smaller facilities where a complete professional staff is not available. Most authorities agree that the so-called "team approach" to evaluation and program planning for these children is most desirable. Nowhere else in the child-care field are so many specialists taxed so heavily in attempting to devise helpful programs. Many disciplines are involved. On the one hand, there is pediatrics, neurology, orthopedics, child psychiatry, nursing, and physical therapy. On the other hand, there is psychology, activities therapies, occupational therapy, speech and hearing, special education, and social service. All are equally important in meeting the special needs for management and training, and in keeping the parents, loved ones, and community involved. All of us concerned with programming for the retarded must acquaint ourselves with the more important methods of each of these disciplines.

Our goals, as always, are to enable the child to care for himself in as complete a manner as possible, to accomplish training of the child to whatever level possible, and to satisfy physical and emotional needs to that degree possible and appropriate. It is the individual (aide or nursing assistant) in direct child care that is the key figure in the achievement of these goals. It is he or she that has to be a "specialist" in all the disciplines we have mentioned, plus a great deal more. She must put to practical application what the consultant recommends. She must stimulate as she gives support, teach as she gives affection, tolerate at she attempts to motivate. This person has the greatest opportunity to teach, to demonstrate, to administer to needs, and to observe and understand problems more completely than anyone else.

We are attempting in this discussion to indicate how intervention by some of the various specialties assist in meeting the child's total needs. Without going into great detail, I should like to summarize some of the things related to the medical disciplines that we have found important, and indicate what persons in direct child care may expect in the way of support, direction, and consultation. First, let us consider the physician's general responsibilities in care and management.

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## The Role of the Physician

The physician, first of all , must be mindful of the total problem of the child. He is interested in having as accurate a diagnosis as possible and in being aware of any medical symtomatology. He must be aware not only of the child's deficiencies, but also of his abilities and must participate in whatever way he can with suggestions related to programs that may help facilitate rehabilitation. He may uncover certain strictly medical problems that require specific therapy that would relate to the child's daily activities. The general evaluation of the child's functional level, aspects of his personality, defects of hearing or vision, problems with eye-hand coordination or fine motor movements, spasticity, associated sensory or perceptual-motor dysfunction all require careful neurological evaluation. Through experience with a great number of children with cerebral dysfunction, the physician may be able to give some opinion as to the child's general prognosis, although accurate predictions in young children can be very difficult (Denhoff, 1960).

Routine pediatric care is in his domain, and he will be interested in seeing that proper immunizations are given, proper nutritional intake is maintained, and that proper records are kept of weight and height measurements, bowel and urinary function, seizures or convulsions, and menstrual periods where indicated.

Determination from the physician of when a child is ready to learn a new step in his self help skills may be helpful. An optimistic attitude, support for the child's program, cooperation, and a hesitancy to sell a hopeless prognosis are essential in his approach.

Signs and symptoms such as fever, gastrointestinal upsets, pain, or loss of appetite, naturally are brought to the physician's attention. A sick child is an unhappy or irritable child who cannot function at an optimal level. With the drugs that are available to combat infectious illness, there is little excuse for most of these illnesses to which retarded children are particularly prone not being kept under control.

## Drug Therapy

Drug therapy has much to benefit the retarded. Drugs for control of convulsive seizures, control of behavior, anxiety, depression, hyperkinetic behavior, acting out, and drugs that aid muscle relaxation comprise a total armamentarium for therapy that controls partly or completely most of the organic and functional cerebral disorders. We can achieve complete control of most seizure disorders and greatly modify the severity of most of the remainder.

Among the more severely retarded, seizures are quite common and we see various types of seizures. Most of the cases respond to average doses of anticonvulsant, but, in some of the seizure problems, relatively large doses of medications and sometimes combinations of anticonvulsants may be necessary for control. In such cases, it is sometimes difficult to control seizures without getting undesirable side effects from the medications, such as drowsiness, gastrointestinal upsets, anorexia, dizziness, or staggering. When side effects are encountered, it is necessary either to try a different drug or drug combination or to utilize lower dosages and perhaps accept the fact that an occasional patient will have an occasional light seizure.

Child care personnel should be cautioned concerning the possibility of a seizure associated with bronchial aspiration of vomitus, food, or other contents of the oral cavity. It is not uncommon for children to have seizures around mealtime. Quickness to get the child in a reclining position with head and face downward, and, if possible, getting the oral cavity and pharynx emptied may be life saving. Most seizures, however, in children, who are on adequate doses of anticonvulsants, are modified and may be very light.

There are times when children seem to be having partial seizures, which will occur over a period of several days during which time they will not eat well, may be dizzy, stagger, have tremors or stumble into things, and may injure themselves. During this period, we have found it better just to allow these children to have quiet and rest, perhaps with a little extra medication for a few days. After adequate rest and attention to any other health problem if it exists (e.g., constipation or fever), they will be up and going at their usual pace. This we have observed quite frequently.

An occasional mild seizure in a child who is known to be convulsive and who otherwise is felt to be on adequate medication probably should not be a cause of major concern. Repetitive seizures should be reported to the physician, who will adjust the medication. Also, the child's activities may have to be decreased if there is too much stress or he is becoming excessively tired. Regularity of meals and adequacy of nutritional intake also play an important role in seizure prevention, since the convulsive child can be very sensitive to changes in blood glucose levels.

Drug therapy, in addition to its importance in control of seizures, is also important in behavioral modification, control of anxiety and acting out, modifying hyperkinetic behavior and short attention span problems, sleep reversals, and the like. When required, drug therapy must be individualized according to the problem and the child involved.

Many retarded children require no medication. They are naturally calm, pleasant, and cooperative. Other children have tremendous swings in the type of behavior with surges of acting out, irritability, or attacks of anxiety or agitation. Some will seem fine and be very pleasant for a period, but, with some small change in environmental circumstance, they develop tremendous states of fearfulness or anger and will become agitated to the point of disturbing everyone in their surroundings. These children need various types of tranquilizers and will respond to certain ones better than others. We try to obtain some behavior modification or modulation without getting too much sleepiness, listlessness, or clouding of ability.

In most cases, tranquilizers are given in an attempt to render the child more amenable to various other forms of therapy. He is either more cooperative or less distractible. He is less frightened by something new and more able to participate in new types of activities. Something he doesn't understand doesn't upset him as much. With less fear, anxiety, or preoccupation with themselves, the children become more explorative and more willing to reach out in their environment and try new things. They can better interpret and evaluate new sensations or new activities. They will socialize a little better. Here is a chance for the Aide or the Activities Therapist to step in, take advantage of the new mood, and make an attempt to push the child ahead several steps in development. Too often, however, when the child becomes less a problem, he fails to get as much attention. This defeats the whole purpose of the drug therapy.

Skeletal muscle relaxants are used primarily in the spastic and some athetoid children. With these, the child can, perhaps, be more comfortable in sitting or can be a little more active than before. Nursing care may be easier. Choreoathetoid children become a little calmer in their movements, and spastic children with abnormal swallowing seem to accomplish food intake more easily. We have found that severely spastic children have fewer bouts of pneumonia and seem to have better respiratory function when muscle relaxants are used. Whether this is related to less aspiration or to better bronchial toilet because of better respiratory excursion is difficult to evaluate.

Muscle relaxant drugs also aid the physical therapist accomplish exercises and neuromuscular training procedures.

Antidepressant drugs are used frequently, especially in the older child where depression exists, in combination with appropriate environmental stimulation and proper program integration. Psychotic or autistic children are generally quite resistant to any type of therapeutic intervention. Given time, patience, certain anti-psychotic drugs, and an opportunity to participate in a compatible environment, these children can be helped. I am sure no one really knows the incidence of psychotic behavior among the retarded, but it certainly is more common than among normal children.

### Orthopedics

The orthopedist has much to offer the more severely retarded group because proper orthopedic treatment can convert clumsy, awkward children into reasonably agile ones and moderately crippled children into mildly disabled ones. Musculoskeletal abnormalities may be manifest in abnormal positions of joints. These are usually reflections of imbalance in muscle tonus. When abnormal joint postures persist for long periods, they may become fixed. These deformities are called contractures. These should be prevented or corrected early. Some children are able to overcome mild disability through remedial exercises or splinting. Moderate to severe degrees of involvement when left untreated often develop into fixed contractures, which necessitate more radical corrective measures.

Muscle imbalance is an early feature of mildly neurologically impaired children. Normal maturation is delayed. When standing is attempted, there is malalignment and imbalance. This may show up clinically as slightly adducted and internally rotated hips, flexed knees, equino varus, or adducted feet. Such problems are common. In the upper extremity, there is the adducted internally rotated shoulder, flexed elbow, pronated forearm, flexed wrist, extended fingers, and adducted thumb. In an early case of athetosis, there is no observed difficulty other than hypotonia. Gradually, however, over a period of months, incoordination and imbalance as well as the development of dystonic movement are observed.

These orthopedic problems were treated traditionally by physical therapy, braces, and leg splints. In mild cases, this was the sole therapy. Deformities were permanent, giving rise to stiff or spastic gait and awkward function of one or both upper extremities, depending on whether the child had hemiplegis or bilateral involvement. Orthopedic surgery is now an integral part of the therapy of cerebral palsy, in even the most mild cases. Surgical treatment of deformities of the lower extremities has the primary goal of helping the patient achieve independent gait. A secondary goal is to improve the gait and prevent further deformity in patients who have failed to respond to more conservative therapy (Silver and Simon, 1966). Too often, however, the orthopedist insists that a normal or near normal intelligence be present as a prerequisite for surgery. We feel differently however, and have found that, in many of the procedures, the retarded respond as fast or even more quickly in some instances to surgery as do children with normal mentality.

In many cases, corrective orthopedic surgery not only aids the child immeasurably, but also aids cottage or nursing personnel. It provides a definite benefit to the overall rehabilitative picture for the child.

Operations designed to straighten feet, release tight heel cords, correct excessive internal rotation of the legs or hips are important in selected cases. Facilitation of motor function in these children is a highly desirable feature of their total rehabilitation. Significant numbers of retarded, nonambulatory children exist who have a higher I.Q. range than many of the retarded ambulatory children. Many of these children fail to progress for the lack of a relatively easy orthopedic procedure on feet, knees, or hips. A tendon transplant on hand or wrist in cases of hemiplegia, for example, may enable the child to dress himself where he couldn't before.

### Physical Therapy

Lastly, I would like to discuss physical therapy and its contribution to management of the retarded. Physical therapy is very individualized. The type of therapy utilized depends on the individual's physical problems, his level of intelligence and adaptive behavior, and his ability to cooperate with the therapist.

Many different techniques are useful. The therapist does an initial evaluation of the child considering many factors. Which muscles are weak? Which muscles are spastic? Does he have normal balance? Does he have good coordination for fine as well as gross movement? Is his motion normal at all joints? Which combination of factors is causing the child's disability? An attempt is made to correct the disabling factors involved; the order and progress of treatment is geared to the growth and development of a normal child. For instance, he is taught to crawl before he is taught to walk.

The following are a few of the treatment methods utilized:

> **Range of motion exercises are helpful in preventing joint contractures, in strengthening weak muscles, in stimulating use of weak arms and legs, and post-operatively in regaining use of stiffened joints or operated joints.**
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> **Muscle and tendon stretching is helpful in conditions where there is an overpull or tightness of certain tendons, such as the heel cords. Heel cords are commonly tight, causing the child to walk on his toes. He is unable to place his heels on the floor. An attempt is made to**

**prevent permanent deformity and help the child gain better function in an adjacent joint. Muscle and tendon stretching is sometimes used as an adjunct to bracing or an adjunct to special training, such as gait training.**

**Muscle strengthening exercises, active and passive, are used to strengthen weak muscles or muscle groups and for muscle re-education.**

**Balance training is vitally important to the child's therapy. He learns head control and learns to maintain his balance sitting in the "puppy" (all fours) position, on his kness, and finally on his feet. Having the child push an item, such as a sand bag or a box along the floor or engage in a "tug-of-war", stimulates his righting reactions by gradually increasing the demands upon the balance mechanisms. An attempt is made to achieve the highest degree of function possible within the child's level of ability.**

**Coordinating exercises are helpful in teaching the child fine movements, making it possible for him to use his hands better for eating, turning pages in a book, or picking up small objects.**

**Gait training aids the child to walk in as normal a fashion as possible. Many different problems are involved, such as poor balance, poor coordination, or muscle imbalances. All are amenable to help from gait training. Attempts are made to teach large muscle groups coordinative function through exercise, use of the parallel bars, and certain motions or movements.**

In all of these forms of therapy, the experienced therapist attempts to encourage the child's cooperation, bringing his attention to focus on the movement or function involved. This is often difficult due to distractability or inability to comprehend the therapist's instructions. Motivation is a very important aspect in physical therapy, and the successful therapist will bear this in mind in all of her treatment.

## Summary

The purpose of this paper was to summarize some of the important aspects of medical services for the more severely retarded, emphasizing what the aide should know for successful interpretation and application of medical recommendations. What the aide may expect in the way of help from the pediatrician, orthopedist, and physical therapist also was reviewed. Conditions in which drug therapy plays an important role were mentioned, and the role of drugs in total rehabilitation was discussed.

## REFERENCES

Denhoff, E., and Robinault, I. P. *Cerebral Palsy and Related Disorders.* New York: McGraw-Hill Book Co., 1960.

D'Wolf, N., and Donnelly, E. Physical therapy and cerebral palsy. *Clinical Pediatrics,* 5(6): 351-352, 1966.

Silver, C. M., and Simon, S. D. Modern orthopedic therapy of cerebral palsy. *Clinical Pediatrics* 5(6): 343-346, 1966.

# MEETING SPECIAL NEEDS THROUGH INTERVENTION BY THE NURSE

Barbara Campbell, R. N.

The purpose of this discussion is to share with you some of the experiences gained by nursing personnel at the Warren G. Murray Children's Center. It is hoped that the discussion will demonstrate the vital, creative role that nursing services can play in a residential situation for the retarded.

## Warren G. Murray Children's Center

The Warren G. Murray Children's Center has a resident population of 700 severely and profoundly retarded residents, 6 to 23 years of age. There are seven H-shaped cottages, each housing 100 residents with 25 to a wing. There are five cottages for 500 ambulatory residents (100 per cottage), and two cottages for 200 infirm residents (100 per cottage). Within each of these cottages, there are facilities for the residents' living, sleeping, bathing, dining, and playing. There are separate areas for clothing, soiled laundry, beauty or barber facilities, and classrooms. There is a medicine room, a doctor's examining room, and several offices. Hot-and-cold food trucks are brought to the cottage kitchen and meals are served in the dining room. In other words, the cottage is home, and the resident need not leave the cottage for any purpose other than to obtain a service offered either in the hospital building or in the Community Building. Our goal, however, is to provide opportunity for new experiences in socialization off the cottage whenever possible.

The hospital offers all clinical services associated with treatment and prevention of illness. There is a dental lab, EEG, X-ray, clinical laboratory, outpatient clinics, and a physical therapy as well as central supply in emergency room. The hospital wards have 24 beds for medical patients and 24 beds for surgical patients, plus ten beds for isolation and four beds for intensive care or post-anesthesia recovery in conjunction with the operating room.

The Community Building enables residents to have the experience of venturing out into the community for classes, movies, church services, and a snack.

Nursing services are responsible for the total care of 200 residents in the infirm cottages and acutely ill hospital patients. Nurses have an overall responsibility for a "visiting nurse" type program in

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the five cottages housing ambulatory residents.

### The Nursing Program

We feel that all personnel need to be imbued with the knowledge that the retarded child has his own individual worth and dignity. We must meet his basic needs of love and security, offering him (as nearly as possible in our facility) a home with a family environment.

Philosophically, it is our belief that while the best nursing care is important in the widest sense of the word, such care should not be an isolated end in itself. Uppermost in the minds of nursing personnel must be the attainment of growth and developmental goals individualized for each resident. In essence, the philosophy might be summarized as an ongoing search for each resident's maximum potential in health and welfare.

Programming for the most profoundly physically mentally retarded consists of maintaining general health, while carefully exposing the resident to social contracts with a large number of adults and children. These contacts result in opportunities for new experiences, intellectual stimulation and social participation. Heretofore, many persons considered such experiences as irrelevant for the profoundly retarded.

Concrete examples of such programming are to be found in the daily routines for the Center's two, 100-bed cottages for the infirm. Every day, each resident is dressed, placed in an appropriate wheelchair or recliner chair, and taken to the dining room for each meal. In addition to scheduled snack and nap time, each resident experiences his individual treatment-training program, depending upon his functional level. Variations range from positioning on a mat to trips to the Community Building for a snack-shop treat or a class session.

Some of the higher-level infirm residents in wheelchairs or on crutches have a "grounds pass" enabling them to move about freely on the grounds. These same residents are involved in off-the-cottage work adjustment programs.

Since the majority of nursing services personnel had no previous experience in mental retardation or in institutional nursing, there is a refreshing lack of stereotyped thinking. Blissfully ignorant of the often found hopeless "do-nothing" attitudes surrounding the profoundly physically and mentally retarded, the personnel, for the most part, have adopted a hopeful willingness to participate in a unique program.

Under the direction of physicians and administrative supervisory registered nurses, the staff nurses, practical nurses, and nursing assistants share an overall responsibility for comprehesive nursing care. These people are charged with all of the usual tasks related to nursing care. In addition, they are involved in teaching of language development, motor skills, and basic self-help skills. Dispensing quantities of affection and simple play experiences ranks high among their helpful activities. Insofar as possible, nursing personnel also fulfill the mother-father role.

Among the discouraging statistics are the facts that at least 85-90 percent of the infirm residents, because of their multiple handicaps, must be fed, and, certainly, the same number are incontinent. Probably the most overwhelming problem is related to the physical strain of lifting and carrying heavy, helpless residents.

Some problems inherent in adequately dealing with the retardate are related to everyday occurrences, such as feeding. Here, behavior shaping techniques are very important (Bensberg, 1965). The child who can learn to handle finger food is well on his way to learning to manipulate a spoon. Even if he cannot be completely independent, he can learn to use his fingers and a spoon.

There are many little tricks that can be used to help the feeding program go more smoothly. Consideration should be given to the types of foods to be fed to certain children. Some of the very severely spastic youngsters require a pureed diet in order to minimize choking and aspiration, which are most serious problems. Some can eventually graduate to chopped foods, and some may become able to take foods of a regular consistency. Establishing safe feeding habits (e.g., ease in swallowing and upright body positioning) are musts. Handles cut from plastic containers found about the household can be put on spoons, making the spoons less awkward and cumbersome for spastic hands to manipulate. The use of small fiexible plastic cups having lids with a hole to stabilize a straw can be very helpful in feeding the very severely spastic child. A slight squeeze on the cup will push some fluid into the mouth through the straw, thus helping to condition a response. The child learns that sucking on a straw is rewarding.

The processes of feeding, speech, and language go hand in hand. Problems of swallowing, drooling, and tongue control are interrelated, and a good feeding program will minimize some of these problems. This is where the speech therapist can be a tremendous help in working with attendants. A mutual sharing of knowledge concerning residents is essential.

There is another rather broad classification of problems which can be handled very well if the attendant understands what is involved. I am thinking of attitudinal reflexes. These reflexes result in abnormal reflex postures. Attitudinal reflexes are actual persistent reflexes which cause pushing and resistance by the afflicted child. Thus, the child may be stiffening and acting as if he is rejecting feeding attempts, while actually, he is very hungry and is seeking to find security and comfort. Understanding abnormal reflex responses may help the attendant by encouraging patience and understanding. Use of wheelchairs with adaptive equipment is very important. You will see obvious improvement — the children will become more comfortable, more alert, and more functional. With proper positioning in a wheelchair, abnormal reflexes are actually blocked.

Imagine, if you can, the absence of sight stimuli if one's line of vision is restricted to the ceiling. If a child is positioned upright, even for a few hours a day, new horizons are open to him. Where needed, support of the body with the hands and forearms can be attained by use of a properly placed tray.

We find that positive reinforcements best fit the retardates' needs. Rather than candies or edibles, we use social rewards of praise, pats, and hugs. From our experience, these seem to be the best rewards. A positive side effect of social rewards is that such gestures are accompanied by words. Hence, the retardate receives the benefit of additional conversation directed to him as an individual.

"Time out" has proven to be a desirable technique to eliminate such undesirable behavior as temper tantrums, spitting, or striking. For example, a child in his wheelchair is removed immediately for a brief period of time from the group, just far enough to receive the effect of segregation. Undesirable behavior in the dining room results in a quiet, but immediate, verbal warning which, if unheeded by the child, is followed by immediate removal from the area. This is accompanied by a brief explanation to the child. Naturally, the child is always fed later, either back in his unit or in the dining area if he should be returned. Denying a meal in order to punish is absolutely wrong, and we feel such action is akin to child abuse.

Nursing staff is studying and exploring the implications of "facilitation methods." This type of sensory stimulation, a behavior-shaping technique, is discussed in detail in Bensberg's handbook (1965). Sensory stimulation, or "facilitation method", is a sophisticated technique, one that calls for more advanced and effective teaching — one of our dreams for the future.

Possible outcomes associated with the utilization of these methods might be reduction of drooling in even the most profoundly retarded, establishment of good swallowing, and establishment of partial to complete bowel and/or bladder control in the physically handicapped youngsters. It is not inconceivable that all infirm children, especially the most profoundly retarded, might develop other desired responses as a result of the individual attention afforded by sensory stimulation or similar programs.

## Conclusion

In conclusion, may I state that we feel that caring for the mentally retarded is a very challenging and rewarding experience. Emphasis must be on a *home* for the mentally retarded, with an ongoing program, appropriate stimuli, and a colorful, happy environment for both resident and staff.

## REFERENCES

Bensberg, G. J. (ed.). *Teaching the Mentally Retarded: A Handbook for Ward Personnel.* Atlanta, Georgia: Southern Regional Education Board, 1965.

# PUBLIC HEALTH SERVES THE MENTALLY RETARDED

John B. Hall, M.D., M.P.H.

The mentally retarded person needs the services of a constellation of specialists. The trend toward his support in a community setting accentuates the need to be aware of the possible contribution of all community agencies. The public health agency has long been aware of the need for supporting families of institutionalized children. In all areas of health activities, the unique contribution of health department representatives has been in the area of interaction with families and/or patients in the home situation.

The public health nurse has always been aware of multiple health problems in families being counselled by her. The comparatively recent survey of children on the waiting lists at Lincoln and Dixon State Schools (1965) indicated that not only did the other members of the family need support, but that the family often had other problems. Family disintegration under the physical and psychological impact of the presence of a retarded child can end in disturbances in other family members. The development of community programs such as day care centers makes family understanding and adjustment even more important.

## The Team Approach

Much is said about the team approach. This means the use of all competencies available in the adjustment of the child and family to each other and to the world. The team approach, indicating commonality of purpose, presumes sharing.

The team frequently includes the psychiatrist, psychologist, and psychiatric social worker. The total support of the retarded child, however, must include more people. We need to concern ourselves with the proper utilization of all resources. The public health nurse's training and experience makes her an invaluable liaison person. She frequents the home, mobilizes the family, sees the need for a unified approach, and is able to channel family findings and needs to the team and the plan for action back to the home. Her contribution in understanding the attitudes of other family members in the home environment can be most helpful.

One of the stumbling blocks is the "confidentiality" of case records. The mentally retarded person does not fit in a slot — each child so

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designated is an individual with individual needs not only in regard to himself but in regard to his family. The status of the child, his capabilities, his potentialities, etc., must be known to all concerned. This means communication to close the tremendous information gap. Mental retardation is not an entity. The fact that there are gradations indicates varying potentials.

Implicit in the multidisciplinary approach is the assumption that all persons contributing have the requisite training and, hopefully, experience to make their contributions effective. The retarded child often has less than average resistance to disease. The child needs the same kind of training and discipline as all children, i.e., supervision and socialization. These things can best be explained and monitored in the home setting.

### Prevention, Case Finding, and Supervision

The area of prevention is the *forte* of health department activity. Prevention of retardation due to phenylketonuria is an example of this kind of activity. Genetics is an area of medical scientific development that impinges on the hereditary possibilities related to mental retardation. This whole research area has more possibilities than the mind can comprehend. Genetic influences on the development of the nervous system raise intriguing possibilities in future development of controlled mental capacity. Genetic counseling is a growing specialty. This kind of activity is certainly in the field of preventive medicine and is as important as immunizations against bacterial and viral diseases. This should be one of the considerations in family planning.

One other area that the public health agency is eminently suited to aid the mentally retarded is through case finding and referral. Proper referral is implicit in case finding, but no referral is complete until the patient appears at the referral agency.

The public health nurse evaluates daily case finding possibilities through such activities as well-baby conferences, immunization clinics, and home visits to preschool children, children with physical defects, or children with behavior problems.

The mentally retarded include not only children but adults as well, and there are too many instances of the retarded being lost when they reach the age of 18. Health departments keep case registers of families with many kinds of problems where continuous supervision is necessary. There are no artificial barriers such as age or income. Within the limits of personnel, continuous supervision is possible. The health department's contribution is effective only insofar as other disciplines accept the fact that their respective contributions are not the total answer to the therapy and adaptation of the mentally retarded person.

In summary, the health department serves the mentally retarded person in several ways: (1) counseling and supporting the patient and his family; (2) helping to develop positive attitudes, thereby reducing the incidence of broken appointments; (3) providing ongoing supervision when needed; (4) finding new cases; and (5) aiding in the development of positive community attitudes.

## REFERENCES

*The Waiting List: A Study of the Mentally Retarded.* Springfield, Illinois: Department of Public Health, 1965.

# THE COMMUNITY LOOKS AT RETARDATION FROM THE PROSPECTIVE OF TOTAL CONTINUUM OF PASTORAL CARE

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There was a time when the community could solve, or thought it could solve, its responsibilities to the mentally retarded by isolating them in some institution in a far off place in the country. That day is past. Currently only four percent of our country's mentally handicapped individuals are in residential institutions (Scheerenberger, 1965). The trend in these institutions is toward a greater return to and increased participation in the normal life of the community. Regardless of where the retarded live, the community has a privileged responsibility to these folks. Privileged? Yes, privileged, because I believe that every public or private servant of the community must accept as one of his guidelines the "test of the least." This "test of the least," which was framed originally by Cardinal Cushing of Boston, states that the measure of the degree of a community's civilization can be found in the provisions and advantages that the community makes for those who are least able to take care of themselves.

In the State of Illinois there are approximately 350,000 mentally retarded citizens that put you to the test. The concept of community responsibility is very good, but it can remain a very ineffective abstraction unless those who are interested in a particular area of concern reach out and elicit the response of the members of that community. In the United States, our Judeo-Christian beliefs are motivation *par excellence* for the individual shouldering of such responsibility.

## Theological Foundation

The revealed word of God tells us that, in the beginning, God said, "Let us make man into our image and likeness;" and, then, God created man to His image. It is that act of creation that establishes the immutable dignity of every human being with the consequent rights. Sad to say, this inherent dignity has not always been respected, and, therefore, rights have been frequently ignored and trampled upon. This has been especially true for the small, the weak, and the "least." The Jewish and the Christian religions have been the champion of his dignity and of these rights — at least in principle. In the Hebrew culture, each child is a child of God and a member of a race chosen by God for a divine purpose. From a Christian standpoint, the value of

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each human being is forcefully expressed in Christ's words, "Anyone who receives a little child in my name receives me." Drawing on these principles, I think that both the Jewish and the Christian tradition in relation to the mentally retarded can be aptly expressed in the words of the Papal message to the 1965 International Catholic Child Bureau Conference: "The problem of the rehabilitation of the handicapped is posed not only in terms of economic productivity and efficiency, but it is established on the basis of the rights of the human person and of his higher destiny. . . . The Church never thinks of its children as less favored because of a diminished capacity nor does it consider them as subjects with fewer rights."

## The Clergyman

The leader of the religious community, the clergyman, because of his total dedication to upholding human dignity, is crucially important in helping society adequately meet the multifaceted challenges of mental retardation. In the past, efforts of Illinois churches and synagogues have not been totally wanting in this area, and religious bodies are increasingly addressing themselves to the educational and social problems posed by mental retardation. Denominational groups have organized private service facilities for the retarded, including nursery and day care programs, special classes and schools, part-time religious education classes, recreational programs, summer camps, counseling centers, and sheltered employment. But these efforts have been scattered and few—too few! I think that the key to increasing services is a clergy that is equipped with knowledge of the problem, available treatment agencies, and professional personnel. With such a background, the clergyman will be able to utilize more effectively his personal resources and those of his congregation on behalf of the retarded and their families.

The following areas are pastoral concern:

*Detection:* The clergyman in his normal exercise of pastoral solicitude is frequently the first professionally trained person to be aware of the existence of a child with retarded development. For him to be effective, he need not be a professional diagnostician, but he must have some knowledge of normal growth and symptoms of mental retardation.

*Referral:* Every clergyman should be in a position to counsel and advise realistically in the matter of mental retardation. While personally he may not know the answer to the more intricate problems posed, he should at least know where these answers can be found.

He should have readily available directories and handbooks of community resources which will aid him in putting parents on the right road to the ultimate solution of their difficulties.

*Ministering to the family of the mentally retarded:* Because the pastor is frequently the confidant for the family of a retarded child, he can do much to allay the anxiety, the bitterness, the confusion, the guilt, and the grief that frequently are present in such a family. To be effective, he first of all must have solved in his own mind the theological implications of mental retardation. Secondly, he must be able to see how birth of a retarded child can be seen as an attack on the parents' own sense of worth, as possible punishment for past failures, and as a rejection by God. He should be able to understand the anxieties and fears of parents and their many realistic concerns about the care of their retarded child. Also, he must be sensitive to the effect that the presence of a retarded child in the family has upon normal siblings. It would be helpful if the clergyman possessed some knowledge of the legal implications of mental retardation.

### The Religious Education of the Retarded Person

As a man of God, the clergyman's primary responsibility is to encourage and to nourish the spiritual growth of each and every one of his "sheep." Although limited in intelligence, the retarded individual is no less a person — a person from whom God expects the love and service that his endowment permits. It devolves upon the minister of religion to provide religious education commensurate with the individual's level of comprehension. In his already crowded schedule, it may be impossible for the clergyman to meet this responsibility personally. If this be the case, it is his concern to see that adequately trained lay personnel are available.

It should be noted that the obligations of the church or synagogue for the religious education of their retarded members are not satisfied solely by a formal religious education program. Lest the retarded member become an isolate in a community, it is necessary to provide for his integration and participation in all of the religious, liturgical, and social activities of his church.

### Community Action

The clergyman shares responsibility with other professional and interested citizens for promotion of services and facilities that will enable every individual to realize his full potential and to prevent social conditions inimical to such development. This latter obligation becomes all the more imperative in light of recent research which reports that the number of retarded persons in the United States is considerably enlarged because of poor, unstimulating social conditions.

Another area of community action in which the clergyman can assist greatly is in the promotion of a social climate in which there is a realistic acceptance of the retarded.

The clergyman might direct voluntary efforts of his youth and adult groups toward assisting and developing programs for the retarded and encourage students toward a career in work with the retarded. Also, he and his congregation might stimulate the building of nondenominational chapels (similar to the military) in state residences for the retarded so they might have an identifiable place of worship and special closeness to God.

These are some of the responsibilities that I view as a part of pastoral concern. To meet these responsibilities the clergyman must be prepared. How can this be done? Some of the following approaches might be helpful:

*Theological school curricula*: Because of the complex demands our society makes upon the clergyman, seminary curricula are overloaded. Subsequently, it does not seem feasible to attempt to introduce a new course of study specializing in the area of mental retardation. The preparation of the future clergyman for adequate functioning in this area could be obtained realistically by introducing mental retardation in various phases of the existing curriculum, especially in courses on pastoral counseling. Exposure to retardation could be intensified by conducting institutes, workshops, field trips, and part-time work in this field, as well as inviting experts in the field to address the student body. It is encouraging to note that the new revision of church directives governing the training of Catholic seminarians, currently being considered in the United States, maintains that, before ordination, seminarians must work in programs for the mentally and physically handicapped.

*"Clergy Days"*: Amplification of "Clergy Days" programs held at variously located schools and hospitals would be of value. Attendance might be increased by soliciting the assistance of the local Association for Retarded Children in publicizing and sponsoring these events.

*Institutes and workshops*: Institutions of higher learning, both public and private, should be encouraged to sponsor periodically two- or three-day institutes and workshops directed at providing clergymen with the knowledge and skill required to fulfill effectively their obligations in this area. Funds for such programs might be sought from public or private resources.

*Courses in how to teach religion to the retarded*: In order for lay personnel to be trained adequately to carry out the church's and synagogue's program of religious education, public and private institutions of higher learning should make available undergraduate and graduate courses on materials, methods, and techniques most appropriate for meaningfully communicating religious concepts to retarded persons.

## Conclusion

This paper has attempted to represent the church community in a look at mental retardation. The perspective taken has been based on faith — a faith that sees the essential need for developing the one talent, as well as the five; a faith that is possessed of a willingness to leave the 99 for the one; a faith that is able to grasp the possibility of the foolish things of the world putting to shame the wise.

## REFERENCES

Scheerenberger, R. C. A current census of state institutions for the mentally retarded. *Mental Retardation,* 3(1): 4-6, 1965.

# IMPLICATIONS OF FAMILY BOARDING HOME PROVISIONS FOR THE RETARDED

Merle E. Springer, A. C. S. W.

The provision of foster care for children dates back in time to antiquity. Slingerland (1919) reports that "under ancient Jewish laws and customs, children lacking parental care became the members of households of other relatives, if such there were, who reared them for adult life." Various forms of substitute family care have been noted since that time. The Elizabethan Poor Laws provided for apprenticing of children until they reached their majority, which was often established as their twenty-first year. Charles Loring Brace in modern American society was one of the first, as a member of the New York Children's Aid Society, to attempt to modernize the foster care plan. Since that time, modern concepts and understanding of the meaning of foster family care have developed in which the various roles of persons involved in this type of child care have been identified.

## Role of Foster Care

The Child Welfare League of America (Slingerland, 1959) has developed a definition of child welfare as a field of practice. In doing so, it particularly relates itself to the role functioning of the parents. Services are identified as those that reinforce, supplement, or substitute the functions that parents cannot perform. The need for such services has come about because of the inability of the parents to fulfill their parental role, because of breakdown in existing social institutions that fail to enhance the parental role, and/or because the child presents problems to himself, his family, and the community. When these problems occur, various services identified as child welfare in nature are brought to bear upon the family and the child in an effort to ameliorate the problem. Foster family care has been identified as one of the services which substitutes the functions that parents cannot perform.

There is a growing recognition and trend toward utilizing foster care as a substitute for the family system in which one finds a mentally

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retarded child. First approaches to providing care for both normal and retarded children outside the home tended to involve institutional care. Various research studies (e.g., Goldfarb and Bowlby), tended to bring about a movement utilizing family systems as a means of corrective experiences for children living outside their own homes. The utilization of family care for retardates, however, has been slower. Morrissey (1966) points out that family care programs for the retarded, although expanding, have not developed extensively. In part, this resistance seems to be related to a number of cultural and professional factors. Morrissey particularly noted that the criteria of selection of patients and caretakers often are implicit and not well defined. One cannot deny, however, that present attitudes toward the retarded, although rapidly changing, tend to be a deterrent to the utilization of family homes. Such attitudes seem to prevail both among professionals and the general community.

## The Need for Foster Care

Foster family care constitutes but one of an array of services that might be used for the retardate and his family, based upon an appropriate assessment of the needs of the situation. Specifically, it is important to identify the basis for substitute care outside the child's own home. The basis for selecting this type of care should be that the needs of the child can best be met in some other type of family situation than that in which the child presently is living. This immediately implies that caretakers of parental figures are unable to meet the needs of the child and that other services will not meet the needs of the child in his own home.

In the case of the retardate, this often comes about because of the particular problems and needs arising from his retardation. Some of these needs may require a more than usual day-to-day care expected of a normal child, including medical and nursing care, special education and training, vocational and employment opportunities, and socialization experiences. The need for separation from the natural family may be temporary if the community and/or the family are able to provide those services to meet the retardate's needs at some later date. In such instances, the retardate again may be reunited into the family system. It should be noted, however, that there are other circumstances which may preclude the return of the retardate to his home, e.g., the child who is legally dependent and neglected due to the fact that he has been abandoned, or the parent refuses, or is failing, to carry out his normal parental responsibilities as a parent. In the latter case, legal action needs to be taken to protect the child. Here, retardation is secondary.

The adverse effects of out-of-home care for a child cannot be overemphasized. Shipe and Shotwell (1965), in their study with Mongoloid children, documented the importance of the child being reared in his own home for the first few years of his life. The comparative study supported the hypothesis of the superiority of home-reared children over institutionalized children, both in terms of intellectual and social proficiency. Their study deducts that early institutional placement appears to affect the development of Mongoloid children adversely.

In a report by the Group for the Advancement of Psychiatry in 1959 (pp. 13-14), it is stated that:

> Accepted psychiatric principles do not support the separation of any child from his family if the only purpose is to make an educational program available to him. In recent years more communities have developed special public school programs for the educable mentally retarded, and some now also include provisions for the trainable child. When such facilities are available, the admission of a retarded child to a residential setting is determined by the severity of other related factors, phychological, social, or somatic.

Adamson and his associates (1964, p. 61) expressed the belief that residential experience offers an opportunity for a full-dimensional approach to understanding and helping the child and his family.

> As a retarded child is observed in a 'neutral' environment apart from his parents, his severe handicap in 'relating for growth' is made evident. The child seems to lack the drive and autonomy to relate through his needs, save in a do-it-for-me manner. Unlike the normal child who uses relationships to build his own individual growth pattern, the retarded child's manner of relating, by virtue of his own innate insufficiencies, often results in distortion in inter-personal relationships. Therefore, if help to families of retarded children is to be truly effective, it must be available to them early in their lives together. Otherwise, as time goes by early distortions pyramid into greater distortions, leading to a lack of meaningful connections between the parents and the child. Through such a lack of connection comes misunderstanding, mistrust, hurt, anger, and a lack of fulfillment in the relationship. What appears later to be a drifting away or rejection can often be traced back to these earlier distortions. Parents cannot be expected to withstand this kind of severe frustration too long, so that often parents are seen who have insulated and defended themselves against this type of repetitive, hurtful relationship. Without help in the early years, the distortions become immutable and parental lack of belief in involvement with the child becomes a way of life.

However, the authors also point out the importance of the parent-child relationship as a sustaining force. They also use methods that are visual and experiential in nature in preparing the child who is to move from his home into that of an institutional setting. Such methods are not new and have been used in general child welfare practice where substitute care has been utilized.

Littner (1950), a recognized child psychiatrist, speaks of substitute care as being "corrective experiences." Without going into detail, this terminology brings into focus the basic purpose for which foster family care should be made available to the retarded child. If foster family care is not the vehicle for reaching this goal, other provisions should be found in meeting the needs of the retarded.

### Problems of Adjustment

The placement of a child in a new family setting establishes a new network of relationships for the retarded child. Up to this point, the child not only has assumed his role in the family system, but he also has had some contact and interaction with the agency system. Foster care now has brought about new parental figures and caretakers, which means that a redefinition of parental caretakers must be carried out if the child is to function successfully in this system. It is in this redefinition process that strain may develop within the intra- and inter-personal relations of the child, his parents, the foster parents, and agency personnel. For the foster parent, he now is assuming certain caretaker responsibilities for a child that often is not legally or biologically his. He is permitted and encouraged to assume certain parental responsibilities. At the same time, he is denied total rights and responsibilities experienced in a normal parent-child complex. The natural parent has certain responsibilities, and on some occasions certain rights, taken away from him. This means that he must redefine his own role and his relationship to his child. If one accepts some of the concepts presented by Zelditch (1955) in differentiating roles in the parent-child system, then we may have a basis for differentiating or identifying problems in role redefinition by the parents. Zelditch has identified the father as assuming an instrumental role which tends to be associated with his employment outside the home and his need to earn and provide for the family. The mother is identified as having an expressive role which includes primary responsibilities of caring for and nurturing the child. Placement of a child with parent substitutes may tend to relieve the mother of certain responsibilities and often has its greatest impact upon her, as contrasted with that of the husband, since she no longer has the primary responsibility of caring for and nurturing the child.

The meaning of foster care to the retarded child has many commonalities with that of other children. The meaning of placement to the child is that he must now relate to two pairs of parental figures if his biological parents continue to see him. In filling his social role as a child, this redefinition is difficult at best, particularly if role behavior manifested by the biological parents now is being carried out by the parent substitutes. Littner (1950) is concerned particularly with the emotional problems experienced by the child. Feelings of abandonment, rejection, and loss, accompanied by certain fantasies as to why placement came about, may occur. He also points out that loss of love objects tends to inhibit reestablishment of close emotional ties with parent substitutes for fear new love objects also may be rejecting of love which is manifested to them. In addition, where sameness and continuity may have had some meaning for the child, both in terms of care, physical surroundings, and social surroundings, he may now find he must adjust to this new physical-social-emotional complex. Special efforts need to be made to assist the child as he moves into this new situation. The utilization of pre-placement visits to foster homes, discussing the same with the child, tends to assist the child at the verbal and experiential levels with the change in living arrangements. Both kinds of activities reinforce supportively the change he is expected to make.

## Agency Responsibilities

The social agency involved in foster care as an agent of society has particular responsibility for children who are living outside of their own homes. This responsibility comes about because of society's recognized investment in its children, as well as the fact that the child outside his own home becomes more vulnerable legally, socially, and emotionally. Therefore, the agency must function to serve as a facilitating agent in helping natural parents, foster parents, and the child in the various adjustments that must occur in foster care planning. In addition, the agency must assume responsibility for determining that legal rights and responsibilities of all parties involved are carefully protected. Therefore, any legal instruments, whether they be voluntary or mandatory in nature, should be appropriately completed to make certain that at all times the child's needs can be met without legal impairments. Such things as authorization for medical care and surgery, permission for religious instruction, authorization for field trips, and out-of-state travel, should be spelled out clearly. If the agency has assumed legal guardianship of person of the child, the responsibilities of the guardian as contrasted with those of the biological parent whose rights have now been terminated should be clearly enunciated to all parties involved.

### Foster Parents

Some comments about foster families are as follows. In attempting to evaluate the applicants seeking to provide foster care, we find a wide range of motivational factors appearing. These may or may not be the same as expressed by the applicant and as viewed by the evaluator. In a study conducted by Day (1951), most applicants stated that they wished to care for or board children because they loved children, they had service motives, or they were seeking some type of companionship for their own child. In the same group of respondents, as viewed by the interviewers, a higher proportion of the applicants were viewed motivationally as needing to prove adequacy, dissatisfaction with own children, and seeking some financial remuneration. It should be kept in mind that these were applicants for dependent and neglected children, and not particularly for mentally retarded children. Other recognized motivations as seen from our experience include real interest and sympathy for children, seeking companionship, wishing to extend parental role satisfactions, inability to produce offspring, and recent loss of love object.

A more recent study by Rich (1965) concluded that there was no single statement of motivation that was very meaningful. Certain factors, however, appeared to have some bearing on motivation for those homes that were seeking to give foster care to retarded children. In about three-quarters of the homes, at least one foster parent had a personal experience of not being able to live with both natural parents as a child, or had lived with a close relative who had this experience. A third of the group boarding retarded children had a handicapped child of their own. Certain families who were not easily accessible to employment, or had a limited employable skill, occasionally looked to foster care as a means of employment to supplement the family income. Foster care was viewed as an occupation based upon their enjoyment in rearing children. Rich (1965, p. 393) also points out that:

> These facts suggest these people feel that their life fulfillment can better be accomplished through their relationships with people than through competition for material prosperity. They are more interested in their families and homes than in the outside world, and we can surmise that they place human relationships higher on their scales of values than money and material goods. This means that foster parents are particularly vulnerable if their foster children do not reward them by responding to their affection. Hence workers must pay them with evidence of agency approval, an example of which would

**be verbal recognition of a completed difficult and rewarding task.**

It is, therefore, extremely important that agencies evaluate motivation of applicants, and make certain that they define their role appropriately as would be in accordance with the needs of the mentally retarded child in his role as a child.

Experience in Illinois shows that various combinations of family systems may seek to provide foster care to children. This would include the childless couple, couples with children, couples having other handicapped children, and one-parent families. None of these factors in themselves should preclude the family's ability to provide foster care to a child. The decision to place a child in any of the above-described systems should be based upon what the child needs and what the family system has to offer.

Our experience has shown that often families who seek to provide care for retarded children include parents who have had a child with some handicap; professionals such as nurses, teachers, psychologists, social workers, etc., who have a particular interest and concern for children with handicapping conditions such as the retarded; and couples who have had very positive experiences in their parental roles with their own children and are seeking opportunities to renew their parental role. In the case of the latter group, if such persons can be found who are unsophisticated, relaxed and unhurried, and have the ability to be expressive in their parental roles, such applicants tend to be effective with the retarded child. Rich's study identified a number of factors differentiated between the family giving care for the retarded child and those that were giving foster care to "normal" dependent children. The former were listed as group R parents. They tended to be slightly older, i.e., in their late thirties or forties, and their natural children were either out of the home or were in their teens. They showed more than usual ability to alter their family routine to meet the needs of the retarded. All families in group R had applied originally to board ordinary children, and two-thirds were seeking to board babies or toddlers. Therefore, Rich's study (1965) points out that often they could look to homes seeking to board infants to supply placements for retarded children at some future date. It should be kept in mind, however, that this is distinguished from families seeking to adopt a child, who as adoptive parents tend to have not had previous experiences as parents and are seeking other types of rewards in their parental relationships.

The Department of Children and Family Services has been involved since 1964 in a cooperative program with the Office of the Superintendent of Public Instruction, Division of Special Education, in providing boarding home resident services for children with hearing losses. This program has come about because of the expanding identification of children with severe hearing losses, the State School for the Deaf has reached its maximum capacity of enrollment, and other communities have not been able to enroll a sufficient number of children to provide a sound educational program. This cooperative agreement now means that the Department of Children and Family Services now assumes responsibility for recruiting, licensing, and the financial assistance of room and board for children in foster homes while they attend special education programs in a given community, but which is located outside the community of their residence. The Office of the Superintendent of Public Instruction makes reimbursement on transportation and tuition in accordance with Special Education Regulations. In order to carry out this program, we have undertaken a recruitment process of families who would be interested in serving these handicapped children on a five-day-a-week basis. Parents are responsible for medical needs, clothing, etc., of the child, as well as transportation to and from the foster home on weekends. We have experienced considerable success in locating families interested in providing a service for these children. Families responding to a recruitment effort for such children include parents of children having hearing losses, professionals, and persons interested in providing a special service to a child. This service enables the child to obtain special education services which otherwise would not be available to him.

Our agency also has had limited experience in locating families for children having other handicapping conditions. These have included children who, because of special medical needs on a regular and consistent basis, needed to have care outside the home. The natural family was either unable or unwilling to provide the same. Consequently, foster placement was indicated. Comparable motivational factors, as well as caretaker types given above, responded to recruitment for these children. Our experience shows that considerable interpretation and preparation by staff with the foster caretakers in advance of placement of these children is extremely important. Such activity tends to reduce the anxiety of foster parents about their role, assists them in being more definitive as to what is expected of them, and serves to interpret the nature of the problem and child with they will be working. Because gratifications with these children are different from those with the usual dependent and neglected children, ongoing recognition and support becomes extremely important in helping these failures to be effective with these foster children.

Social agencies are increasingly utilizing group methods with clients, foster parents, and adoptive parents. Such approaches have been found to be very productive in assisting foster parents to fulfill their roles. Group meetings, skillfully conducted, have proven to enhance communications between the agency and the foster parents. This process has served to help the families to be more definitive in their roles, to work out problems and conflicts about their roles, to be less defensive and more receptive in their utilization of casework help, and often to be supportive and enabling agents to other foster parents in the group. It would seem that group activities also might be envisioned to be educative in nature in preparing families who would be assuming responsibility for retarded children, as well as enhancing their understanding of behavior, social, emotional, educational, and medical problems particularly relevant for the retarded. A variety of activities may be planned which would be both formal and informal in nature. This could include agency and non-agency personnel who could speak with authority based upon their professional knowledge and training. Such foster families also might be encouraged to be active participants in existing associations for the retarded, as well as action groups within the community who have concern for the needs of the retarded.

### Recruitment of Foster Families

Recruitment methods and techniques for foster parents have become more sophisticated and challenging in recent years. The former attitudes by society about foster care seem to be changing. In the past, it appears that persons who assumed responsibility for children unable to live with their own parents were given recognition in the community for their service motivation. Thus, in addition to certain personal gratifications of working with the child, foster parents also received the benefit of community recognition for this service. However, this appears to have changed. This change seems to have come about because it is more difficult to be recognized as an individual providing service in a mobile, transit society. Other sources of recognition by the community are more easily and on a wider basis obtained. Also, other service opportunities that do not require the intensity of involvment as foster care are now available. This, plus the constant stress by the news media to take advantage of consumer opportunities has made foster care recruitment quite difficult. Our organization, as many, has attempted to constantly upgrade our methods and techniques of recruitment. These have included more traditional methods, using the various news media such as TV, radio, and various house organs of religious, social, fraternal, and occupational groups. News releases, stories of actual cases, and classified ads all have been developed. On different occasions interviews with foster parents on TV and radio have been used.

Other methods have included displays and booths at county fairs. Posters on city buses and billboards also have been utiltzed. We are constantly seeking and utilizing opportunities to speak to various groups about the need for foster care.

Our experience has shown that recruitment efforts are more productive when a continuous recruitment activity is carried out. Although flooding the news media at sporadic times regarding the need may produce a significant increase, continuous recruitment seems to be more beneficial. Also, we have found that the utilization of present foster homes in telling their story and locating friends or other persons to become foster parents is the best, most productive source of new foster parents. Consequently, from time to time group meetings are held with foster families in communities to advise them of our need for foster homes, as well as letters going out from administrators of the agency to foster families advising them of our present needs. News releases that tell a specific story regarding a need for a family for a specific child also have been productive. Under these circumstances, however, one must cope with trying to channel applicants into providing care for other children, once a specific family has been found for a given child. Experience also has shown that staff must be ready to respond quickly and promptly to inquiry, to reduce the amount of withdrawals when families express an interest in foster care.

### Selecting Foster Homes

It would appear that a few comments regarding the foster study process of applicants would be in order. Although families cannot be expected to incorporate all that is said at the beginning of the study process, it is particularly important that they quickly be advised as to the agency's expectations of their role as foster parents and that the applicants have some understanding as to what they can expect of the agency and the type of children with whom they would be expected to work. This information very quickly brings into focus for the applicant the nature and extent of commitment which he would be making as a foster parent. It is also extremely important that the agency assess as quickly as possible whether this family has potential to function in a foster parenting role. Skillful decision-making is needed very early in the process to avoid complicating and lengthy rejections of the foster family. Our experience has shown the more contacts the agency has had with the family, the more difficult it is to reject them as applicants. The approach in studying applicants is to assume they have positive motivation and capacity for growth to develop in foster care until they have proven themselves otherwise. The study process includes an evaluation of the family's capacity to function in a foster parenting role, the readiness of the family as a whole to accept a foster child into the home, the ability of the family to meet any special needs of given children, the family's acceptance in the community, as well as the community's acceptance of foster children. The family must be recommended by their physician as being medically able to assume this responsibility. Also, the physical surroundings of the home should be such as would be conducive to providing a healthy social experience for a child.

### Financial Considerations

In considering cost factors of home provisions for the retarded, the overall needs of the child need to be considered. Foster care costs for normal children tend to be somewhat "lower;" however, as handicapping conditions appear the unit cost increases. Most basic provisions of foster care include a basic room and board allowance based upon the age of the child. In addition to this, other allowances might include clothing allowances, personal spending allowances, and a variety of miscellaneous items which cover such things as haircuts, shoe polish, etc. Special lump sum allowances may be given for non-recurring items such as purchase or rental of school books, musical instruments, graduation fees, etc. Most foster care agencies also provide some medical and dental service coverage which usually is direct payment to the vendor providing the service to the child.

Foster cost factors for children with handicaps tend to increase proportionately to the needs of the child. Throughout the United States a subsidy is usually provided to the families, over and above the items mentioned above. This serves as an inducement for persons to take children with handicaps. Also, it provides some compensation for the actual personal investment that is needed in serving such a child. The amount of subsidy varies, but is in the geneal area of $50 to $150 per month per child. The established cost for any given agency is based upon their operational plan and somewhat on the availability of foster home resources for such children. For the retarded, special allowances may need to be considered to defray transportation costs, lodging costs if diagnostic and other services require overnight trips, etc. Agencies planning to implement an adequate foster home program for the retarded need to be prepared to come to grips with the above cost factors.

## Summary

It is important to recognize that foster care provisions should be viewed as a third line of defense in the array of services for children. The first line of defense should be viewed as that of the home in which other social institutions within the community serve to support parents in carrying out their parental role and responsibility with the retardate. This should include the school, recreational, social, and vocational opportunities for the retarded child and his family, as well as any variety of counseling services needed to assist him in this role. The second line of defense should be recognized as being the provision of supplementary type services, which would include day care and/or housekeeping or homemaking substitutes within the child's own home. It is only after these services have proven to be ineffective in helping the family to meet the retarded child's needs that foster care should be considered.

In considering the basis for foster care, certain areas were identified above. This might include the inability of the parent to carry out his role, and/or educational, medical, vocational, or socialization needs of the child to be found only outside the family home. However, it has been pointed out that a whole new complex of relationships develops once foster care has been undertaken. This includes new parental relationships for the child, a redefinition of responsibilities by the natural parent, and a particular and greater responsibility on the part of the agency in relation to the child and his family. Just as communities need to be helped to understand the needs of the retardate in his own home, it is particularly important that communities be assessed as to their understanding and acceptance of the retardate as he moves into a foster home.

Our experience has shown that certain professionals, parents having had handicapped children, and parents seeking satisfaction in extending their parental roles, often are good sources as potential foster parents. Other studies have shown that parents who have had positive experiences with their own children are particularly suited to provide care to foster children. Group activities with foster parents also have proven to be very effective in enhancing their service to the agency. Foster parents, along with continuous recruitment activities, have proven to be the best way to recruit new families. Although society looks more positively on two-parent families with children, other familly systems have proven successful. The studies quoted above indicate that families having had children of their own tend to make better foster parents.

Exceptions to the above obviously need to be made in relation to the specific needs of the retardate and what the specific applicant has to provide within the community in which he lives.

## REFERENCES

Adamson, W. C., Ohrenstein, D. F., Lake, D., and Hersh, A. "Separation Used To Help Parents Promote Growth of Their Retarded Child," *Social Work,* 9(4): 60-67, 1964.

Day, Gladys D. *Home-Finding — The Placement of Children in Families.* Washington, D.C.: U.S. Government Printing Office, 1951.

Group for the Advancement of Psychiatry. *Basic Considerations in Mental Retardation.* New York: Group for the Advancement of Psychiatry, 1959.

Littner, Ner. *Some Traumatic Effects of Separation and Placement.* New York: Child Welfare League of America, 1950.

Morrissey, J. R. Status of family care programs. *Mental Retardation,* 4: 8-11, 1966.

Rich, M. Foster homes for retarded children. *Child Welfare,* 44: 392-394, 1965.

Shipe, D. and Shotwell, A. M. Effect of out-of-home care on mongoloid children: A continuation study. *American Journal of Mental Deficiency,* pp. 649-652.

Slingerland, W. H. *Child-Placing in Families.* New York: Russell Sage Foundation, 1919, p. 27.

Slingerland, W. H. *Child Welfare as a Field of Social Work Practice.* New York: Child Welfare League of America, Inc., 1959, pp. 6-7.

Zelditch, M. "Role Differentiation in the Nuclear Family." In: Parsons, T., and Bales, R. (eds.). *Family: Socialization and Interaction Process.* New York: The Free Press of Glencoe, 1955, pp. 339-342.

# SOCIAL SERVICES IN RESIDENTIAL CARE FACILITIES FOR THE MODERATELY AND SEVERELY MENTALLY RETARDED

Patricia Tate Bertrand, M.S.W.

The present emphasis on services beyond good care has emerged from the changing values and attitudes about mentally retarded persons, residential facilities, and community programs. Private, as well as public residential facilities, are being urged to be important spokes in the wheel of comprehensive services. This month, a report about the President's Committee on Mental Retardation listed ten recommended areas for action. Two of these are: (1) more public and private partnership in program development, services and research; and (2) renewed attention to residential facilities to take into account the special needs of the retarded (NARC, 1967). If the now-accepted concept of "continuum of care" is to be a reality for each individual, persons in charge of programs must take responsibility for joining with others to fill service gaps. Without effective coordination, enabling all persons to reach their potential will be an unattainable objective.

Once, our society's philosophy urged permanent removal of retarded persons from their communities. The social trend today is for communities to provide services to the handicapped and disadvantaged. Within institutions, emphasis has shifted from custodial care to education and training for community living. Kindness and physical care, even for the most profoundly retarded, no longer are deemed sufficient. Both researchers and direct-service innovators are discovering new avenues to gain access to retarded persons' potential. The formerly bed-ridden are learning to crawl and show awareness of others. Those from whom nothing was expected are feeding themselves and responding to attention. The unmanageable are becoming manageable. Formerly illiterate adult retarded are reading. The many evidences of changed behavior and increased learning should convince us never to give up on the unresponsive client or resident.

## Social Adjustment: Needs and Services

Integration of services and coordination of activities are highly important because of the multifaceted implications of the behavior and problems of the retarded. The retardeds' complex biological, psychological, and social needs require a multidisciplined approach if each individual is to reach a productive level of personal and social function-

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ing. Improving social functioning and preventing further social dysfunctioning are social workers' prime concerns.

Self-care habits affect whether children are in school. Correction of management problems may determine their entrance into an institution or return to a community. Acquisition of basic academic skills influences job opportunities. Physical appearance affects how others react. Correction of speech defects affects how retarded persons feel about themselves.

You may have heard it said: "The child is retarded, not the retarded child." "Emphasize the child, not the retardation." "Retarded persons are more like persons of average intellect than they are different." These statements reflect the commonality of all human needs, including love, attention, companionship, accomplishment, appreciation, and acceptance. When these needs go unmet, retarded children, like all children who feel frustrated, confused, inadequate or rejected, will develop reactive behavior or neurotic problems. Then, a plea is made for appropriate treatment services. Parent groups, now joined by many professionals, are still struggling against discrimination in services for retarded children. It took a president of the United States to turn the tide (President's Panel on Mental Retardation, 1962).

In addition to common human needs, the retarded also have special needs. The special needs of the moderately and severely retarded generally are related to difficulties involving one or more of the following: *self-care* and management, e.g., toileting, feeding, dressing; *personal behavior,* e.g., social poise, personal grooming, cleanliness and table manners; *communication; coordination,* e.g., posture and walking; *awareness of others and respect for their rights; suggestibility and poor judgment.*

These special problems, characteristic of most trainable retarded persons, require special services, primarily in the areas of habit formation and social training. With proper training, these retardates can adapt to family living or to group life within the residential facility.

## Social Work Focus

The provision of effective social services is based on understanding the individual, including his needs and his relationships with all aspects of his environment. Environment includes everything outside the person — family, peers, programs, neighborhood, community or residential facility.

While social work functions may overlap somewhat with other disciplines, there are differences in focus. Social work focuses on social functioning and treats social disability.

The target for social work intervention may be the person or his environment. Social work may create or coordinate appropriate resources within a residential facility to increase the retarded's functioning and reduce their social disability. It may stimulate the development of necessary community resources so that retarded persons may remain in or return to the community. It may assist families sustain or restore their equilibrium. In essence, social work has two major functions: *purveying* and *procuring* services (Shade, 1967).

A "purveyor" uses his knowledge and skills to give *direct* services to people through dealing with the behavior or problem preventing appropriate and satisfactory relationships with people and other areas of environment. The purveyor works directly with the retarded, his parents, and other concerned persons.

A "procurer" gives *indirect* services through planning, consulting, administering, or supervising. The procurer identifies and calls attention to flaws and gaps in services, and takes steps to remedy the situation.

Communication is the social workers' stock in trade. You have heard social workers called "caseworker," "group worker," and "community organizer." Today, the social worker is all of these things, as well as being a purveyor and procurer of services. He can be found doing such tasks as completing social histories, treating people's problems, and locating and developing resources. How they go about doing all of this reflects primarily on their knowledge and utilization of communication skills.

To illustrate, social workers formulate social histories and treatment plans based largely on understanding how the resident and others significant to him have communicated to each other. What is said and not said; a look; tone of voice; a smile; a blank expression; posture; how one feels or doesn't feel about a situation, another person, or oneself are all forms of communication. Social workers interpret both verbal and nonverbal behavior. Indeed, professional social workers spend much of their two years in graduate school learning how to develop and sharpen communication skills as a key method of eliciting information and of helping people improve their situations.

How can this conceptualization be applied to enhancing services in residential care facilities? In attempting to answer this question, I will review the areas of social services traditionally offered in facilities for retarded children and adults and consider recent trends.

### Preadmission Services

The first area of service is preadmission. This usually begins with evaluating the appropriateness of the application for residential care in terms of the particular residential facility being considered. Social workers are trained to utilize community resources, which enables them to help parents make alternate plans should keeping their child at home be indicated. If community resources are unavailable or the child cannot be maintained in his home, the type of residential placement is determined solely on the needs of the retarded. Social services thus acts in the best interests of each retarded person by processing his application to their facility or by helping the family place him in other residential care, such as group homes, foster care, or boarding homes.

Often, parents have been led to believe that their retarded child will adversely affect either themselves or their other children. Many of us have been indignant with professionals who counsel without adequate knowledge of either mental retardation or the individual families. This indignance is often directed at physicians and clergy because of the undisputed authority of their advice. We are indignant by inappropriate or ill-timed counsel which removes children from their parents. We are shocked by countless stories of distaught parents who, in their desperation and urgency to do what is right, deplete their savings and mortgage their possessions. Social workers have spent many hours dealing with parents' upset feelings as a result of such experiences. Because such practices affect people who turn to the residential facility for services, the residential facility should consider remedial action through its social services department.

We also might be indignant by the behavior of professionals who shield and overprotect parents by withholding information or the benefit of their professional experience. Telling parents they are too dependent or too weak to handle adversities reduces their ability to make appropriate decisions. It also ignores the parents' right to know. Parents may be in a temporary state of crisis, but most of them are as well adjusted and mature as parents of children with normal intelligence or any representative population group. Social workers have been as guilty of this practice as anyone. They have communicated to parents that the child is best off in a residential facility when the child would be better off in a family. They also have stated that placing the child in an institution is in the child's best interests when, in fact, placement may be necessary because of the family situation. Parents, like all of us, seem to hear what is convenient or desired. Reckoning often comes later. The presence of a retarded child, especially one whose handicap is obvious and severe, affects family equilibrium whether or not the child remains at home (Slobody and Scanlan, 1959).

Research gives evidence that retardates who spend their preschool years in a family fare better in a residential facility than those who have not experienced family life.

Responsibilities of social services include sharing both knowledge of retardation and information about the extent and adequacy of residential and community resources. At preadmission, social services should assist parents digest and sort out information, examining alternative to residential placement. The focus is on giving parents support while helping them to cope with the facts and realities of their situation. Professionals should communicate to families that they have strengths and that professionals are available to help them mobilize their personal resources.

Preadmission services move from decision-making to preparation of the child and his family for separation. Regardless of the relief a family might experience, separation frequently results in feelings of anxiety and guilt. Physical separation is emotional separation, and often there is a difficult period of family adjustment. Group counseling with husbands and wives experiencing similar difficulties has proven effective; however, neither counseling nor reassurances can substitute for the parents' knowledge that they have done all they could.

### Admission Services

At admission, social services set the stage for parents' future behavior toward their child. In their role as representatives of the residential facility, social workers communicate what is expected of parents and what they, in turn, can expect from those who will be caring for their child. It is recommended that parents talk with staff members, including aides, responsible for the child's daily care. Seeing evidence of staff concern and interest conveys hope and encouragement to parents.

### Services During Residency

During the retarded's residency, social service personnel usually establish liaison between the retarded, his family, and community. This includes giving direct services to the retarded, working with him individually or in a group.

I have found group process with both the retarded and their families to be the most effective. It tends to counteract the social isolation experienced by both retardates and parents.

There is much in the literature about the dynamics of parental reactions to having a retarded child and about various techniques directed to providing maximum adjustment for both the retarded and their families. I will not discuss these further, except to state that generalities should not be made about parents' problems and needs. Also, it is important to recognize that parents come to grips with their troubled feelings at various times and should not be expected to respond to offers of counseling at the convenience of professionals.

Some parents can handle their feelings without any professional help. What they may require is information about the nature and extent of their child's problems, how he is progressing in the residential facility, and what community resources are available. Some parents may need intensive counseling, others only occasional counseling. What is required is that social services reach out to families, communicating the facility's interests, concerns, and availability of help.

Sometimes, social services supervise the retarded's daily living, such as in cottage programs, or provide consultation to aides and child care workers. Social service functions include seeing that the retardate's needs are being met in all aspects of living and programming that affect social functioning.

Social workers also can be utilized for inservice trainig and for supervision and consultation of auxiliary personnel. Social workers are one of the disciplines which can help to interpret the social behavior of the retarded.

The environment of the residential facility is important to enhancing social functioning. Therefore, social services are concerned with the total milieu of the facility, including how programs are organized and adapted to meet the retarded's needs, staff relationships, staff concepts of retardation and program goals.

Because social workers function both within and outside the facility, they are able to see how the residential facility operates as part of the total "continuum-of-care" spectrum. They are in a position to assist in the evaluation and formulation of policies. For example, three policy changes recently were effected in a residential facility by social work students during their practicum experiences: (1) participation of families in their children's evaluation conferences; (2) social work initiation in the development of community programs, such as day care services; and (3) parent group counseling as part of admission services (Betrand, 1967).

A residential facility that wishes its staff to be imaginative, creative, and adventurous in giving service will provide a climate where ongoing assessment of residents and approaches are routine. This will lead to needed re-examinations of theoretical treatment formulations and techniques. It will encourage all levels of staff to focus on solving whatever problems the resident is presenting. Amazing gains have been made by aides and other subprofessionals when the focus is on the individual and not on the diagnosis.

## Discharge Services

Discharge again brings in social services as a bridge between the retardate, his family, and community. Discharge planning includes locating needed community resources. Simply finding a place to live is not enough. Special education, day programs, vocational training, and opportunities for social activities all need to be considered. Social services assists families who are interested in having their children returned home. They aid the retarded by helping them adapt to family and community living. They consult with operators of foster homes, group homes, nursing care facilities, and boarding homes which can offer the retarded a warm, sheltered, and stimulating environment.

Community social agencies frequently need to become involved with the discharged retardate. When these agencies, through their "no-vacancy signs," communicate their disinterest in doing so, the role of the residential social worker becomes one of interpretation, consultation, and education. Residential personnel and community agencies must work together harmoniously to insure against the retardate and his family becoming caught in a maze of inadequate or nonexistent services.

## Summary

In summary, social services specifically directs its attention to enabling the retarded and their families achieve maximum social functioning while treating or preventing social disability. Fulfilling this obligation frequently requires intervention with the retarded and/or their environment. Effective social work depends upon the interaction of many professionals representing both residential and community programs.

## REFERENCES

Bertrand, P. T. Issues in social work education affecting mental retardation content. *Occasional Paper, No. 3.* School of Social Work, University of Wisconsin, Madison, 1967.

National Association for Retarded Children. Mentally retarded emerging from isolation according to President's Committee report. *Children Limited,* October, 1967.

President's Panel on Mental Retardation. *National Action to Combat Mental Retardation.* U. S. Government Printing Office, 1962.

Shade, Oscar, Concepts of purveyor and procurer. School of Social Work, University of Wisconsin, Madison. Personal communication, 1967.

Slobody, L. B. and Scanlan, J. B. Consequences of early institutionalization in mental retardation. *American Journal of Mental Deficiency,* 63(6), 1959.

# AN ORGANIZED VOLUNTEER PROGRAM IN A RESIDENTIAL FACILITY FOR THE RETARDED

### Jean Slocum

The rationale for an organized volunteer program in a residential facility for the retarded is twofold. First, a volunteer program provides additional and personalized services for the residents. Every human being has certain emotional and psychological needs which are best met through social interaction. A volunteer program offers unlimited opportunities for meaningful interpersonal relationships. The mere fact that a volunteer comes to the home or school, not because he has to but because he wants to, is of great value. Even the most severely and profoundly retarded seem to sense that a volunteer is someone who "cares."

Secondly, a volunteer program serves to integrate the home or school for the retarded into the total community. Volunteers are in a unique position to interpret the facility's programs and problems to other citizens. This increased interest and understanding leads to community acceptance and support of programs for the retarded.

A volunteer program must be designed to meet the needs of a specific facility. Size and location of the home or school, ages and abilities of residents to be served, and availability of volunteers are some of the factors which should be considered.

## Administrative Aspects

Staff-volunteer relationships are of critical importance. All of the staff should have a part in determining how volunteers can best be utilized. Volunteer assignments and limitations must be clearly defined. It is most important that volunteers are not superimposed on staff members. The best working relationship will have volunteers serving with assistance and guidance from the staff.

When the framework of the volunteer program is established, the responsibility for coordinating or directing the program is delegated to one person. This person could be an employee or a volunteer. The program should begin with a few volunteers and expand slowly so that staff and residents will make a smooth adjustment to the presence of outsiders.

Orientation for volunteers should include just enough general in-

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formation concerning mental retardation, the facility, and its residents to make the new volunteers feel comfortable. Avoid overtraining. Volunteer's "differentness" is an important part of his effectiveness.

The volunteers will need a place to work. Necessary equipment should be readily available.

Records are a necessary part of an organized volunteer program. Records of volunteer attendance and activities are useful in evaluating the program. Also, formal recognition and awards for volunteers are often based on hours of service.

## Volunteer Activities

Traditionally, volunteers have provided parties and entertainment for the retarded. Recently the emphasis has shifted to doing things "with" the residents rather than "for" them. Assignments have become highly individualized and are often on a one-to-one basis.

Some of the activities for the severely and profoundly retarded in which volunteers have been successful include language development, religious training, self help skills, and developmental activities associated with special education and physical therapy. More and more volunteer activities are taking place outside the facility as volunteers make use of community facilities (e.g., parks and play grounds) to enrich the lives of the retarded. Tangible benefits of these activities, although important, remain secondary to the goal of providing the resident with feelings of self worth through opportunities for social interaction.

## Recruitment and Selection

Methods of recruiting volunteers vary. A good volunteer program coordinator will know the goals and philosophies of the various community organizations. Organizations whose aims are compatible with the goals set for the retarded can be approached directly and their members offered the opportunity to volunteer.

Selection of volunteers is one of the duties of the volunteer program coordinator. Some important considerations are dependability, regularity, patience, and attitudes toward mental retardation. If the first few carefully selected volunteers find their services rewarding, they become enthusiastic and dedicated recruiters. This does not preclude the responsibility of the coordinator to be selective. Sometimes, in an eagerness for community acceptance and approval there is a tendency to disregard the volunteer standards set by the staff. This does nothing to enhance the image of the facility or its retarded residents.

Citizen interest in mental retardation continues to grow. If this interest can be guided through organized volunteer programs, beneficial results will accrue to the retarded, those who care for them, and the total community.

# TRANSPORTATION SERVICES FOR THE RETARDED

Philip R. Jones, Ed.D.

The material presented in this paper is not based solely on transportation for the retarded but is also based on transportation for all handicapped children including the educable and trainable mentally retarded in the Champaign Community Schools. Also included are examples of transportation utilized by small school districts within a 50 mile radius of Champaign who send some 100 handicapped students to the Champaign special education program. The purpose of this paper is to examine methods, problems, and costs of transporting children.

## Methods

A transportation method used extensively in metropolitan areas is public transportation service. This method which often is coupled with a student rate during school hours or use of student tokens is generally not available to the regions and areas under consideration at this conference. Where public transportation is available, it may be of great use in transporting educable retarded. The use of such facilities for the trainable and below would be questioned by the speaker due to the level of functioning of the students. In the case of young adult trainables, this method could be used but only with caution.

In some cases, transportation may become a project of a local service club. An example of this plan exists in Champaign for the Happy Day School operated by the Champaign County Association for the Retarded. The Volunteer Bureau has sponsored the project for the past few years. A Volkswagen bus donated to the Volunteer Bureau by the local VW agency is driven each day by members of the Bureau. An additional adult also rides the bus to assist with the children while riding to and from school. Auto dealers in other communities may make similar style vehicles or station wagons available for such projects Don't be afraid to let the dealer put his name on the vehicle as the sponsor of the project.

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Private cars driven by parents or volunteers are a method frequently used to transport students. This method often is not too logical when long distances are involved unless the driver is employed in the community where the service is located. Use of the driver as a volunteer or paid employee at the center is also a possibility not to be overlooked.

Up to this point, methods of transportation considered fall in volunteer-donation categories. Most schools or service centers for the retarded will, out of necessity, resort to these methods in their early development. A point is reached where the number of retarded served results in consideration of contracting, leasing, or purchasing transportation equipment.

Taxis, which are expensive, are often an area of initial consideration when contracting for service is initiated. The taxi has an advantage of transporting small groups from scattered areas of the community and can on a regular contract basis allow for better time scheduling than results with a larger vehicle being used as a carrier.

Beyond the taxi, larger vehicles come under consideration whether lease, contract, or purchase is the most feasible arrangement.

Nine-passenger station wagons are as flexible as cars or taxis, but, in all probability, will not have as long a serviceable life as would the carry-all type of vehicle. The carry-all also can be obtained in the nine-passenger model or up to a fifteen-passenger model. The carry-all still performs and handles much like a car or station wagon. It can be obtained with doors allowing a wide-side opening to facilitate boarding by children with physical handicaps. A lightweight ramp can be provided to accommodate a wheel chair, if necessary.

A school bus, which can transport large numbers of children, presents some problems due to its size. The larger the vehicle used, the more difficult it becomes to drive in business, residential, or rural areas. Another consideration, of course, is the number of children to be transported. If the school enrolls 30 to 40 children, a bus may appear to be the best solution. Remember, however, the bus can't be in all places at the same time. Therefore, it may be much better to consider three or four carry-all vehicles to arrive at a much better time schedule.

## Problems

With school just a few weeks underway, the problems of transportation for some 500 special education class students remain fresh at hand.

Typical questions and comments by drivers, parents, teachers, and kids included the usual:

> Where does this extra lunch go?
> Can you stop for my boy later in the morning?
> Who's the kid who doesn't belong here?
> Can you stop for my girl earlier in the morning?
> Where's my lunch?
> You can't get there from here.
> The kids drove me nuts when I stopped for the train.
> Johnny doesn't like to ride the same bus as Billy.
> Can you drop my child off last in the afternoon?
> Can you imagine that driver telling MY boy to sit down!
> Where's my kid?

These questions are typical and simply illustrate certain types of problems. Prior planning, while it may be quite thorough, does not solve all problems.

Let's examine some problem or potential problem areas in a little greater depth with some possible solutions.

Scheduling of transportation equipment and routing requires the skill of the lead character in The Music Man — you've got to know the territory. Consideration should definitely include the amount of time spent by any given child in getting to the school or service for him. The age of the child may well dictate the maximum length of riding time. Getting all the children to and from the center at the proper time is an important factor in selecting the method or combination of methods to be used for transporting students. A child in a remote area presents a particular kind of problem to the schedule maker. Here may well be a place to augment the major transportation plan with a taxi or volunteer worker.

Safety becomes a primary concern when transporting children. An article recently circulated by the Office of Public Instruction Materials Center for Handicapped Children cited a report of the American Academy of Pediatricians which had become concerned over the increased injury rate of children transported by school bus. To quote (Newsletter, 1967):

> In an official statement by its Committee on Accident Prevention, the Academy urges pediatricians across the nation to check the school transportation equipment in their own areas and see that it meets minimum standards. Parents active in PTA's might also undertake such a project.
>
> The nine minimum standards endorsed by the Academy are those recently recommended by the Institute of Traffic and Transportation Engineering of the University of California in Los Angeles. After studies in simulated bus crashes it recommended the following:

**Seat belts, the lap type; backs of seats at least 28 inches high to support the head; seats firmly anchored; minimum of half-inch thick padding on all rigid structures; collision-resistant structures at truck and car bumper heights; safety windows that don't pop out on impact; no rigid protruding structures inside the bus; a seat for every child, no standees during transport, and four full-size emergency exits. Children should also have bus drills to learn to use emergency exits, the Academy noted.**

What about liability? In the now historic case on tort liability of school districts, the courts held the Kaneland school district liable for students injured and killed in a school bus accident. Adequate insurance coverage is a must whatever method or device you select for your transportation needs. Volunteers should be informed of their liability and need for adequate insurance. Removal of the maximum award for wrongful death by the current legislature has even greater ramifications in the field of liability and insurance.

While liability does present major problems, it forces those of us involved in transportation of children to be ever mindful of safety procedures. Editorially speaking, this is good!

Not to be overlooked as a problem in transportation of children, what can be done about weather and its influence? In a word — nothing. Weather does play a large part in bringing transportation problems into focus. Weather literally speaking can foul up the best rolling transportation plan. It is not necessary to elaborate in this area.

Problems can often develop with drivers whether volunteer, contracted, or paid by the school or center. In general, the author believes the problems are less frequent and resolved more readily when the school owns its vehicles and employs the drivers. Basically, many problems can be avoided if you are the employer.

Drivers of vehicles transporting children must like kids. They also must be able to enforce some very necessary rules of conduct. Not everyone is a good teacher, and not everyone is a good driver.

Our experience has shown the two-way radio to be a most useful device on a vehicle transporting students. It is amazing how the number of problems with transportation decreased when the Champaign schools installed radios in buses.

### Costs

Obviously, the lowest costs are incurred when a volunteer or donation plan is used. There still may be costs involved in this type of arrangement. While they are not direct costs of transportation, long distance telephone calls, mailing costs, and others can be attributed to transportation under a volunteer plan.

When making a decision regarding contracting for, leasing, or buying transportation equipment, one point should be kept in mind. The contractor or leasing organization is in business to make a profit. You may well resort to these methods, however, due to lack of capital to purchase the equipment initially. A lease-purchase agreement may be a possible way of securing needed equipment.

In general, owned equipment appears to be most favorable in terms of fewer problems, least cost, and greater control.

Regardless of the method selected, competitive bidding reduces overall costs. Some school districts, however, have been placed in a bad position by accepting the low bid by a contractor only to find the contractor cannot perform the service when school opens. Requiring a performance bond be submitted with the bid only ups the bid price, and while you may wind up with money, you still may not get the transportation needed and expected.

Competitive bidding in purchasing vehicles does result in lower costs. Many companies manufacture the types of vehicles discussed and they are anxious to make a sale.

What kinds of costs are involved? The only cost figures available to your speaker are those for the Champaign schools last year. With the exception of one child, all special education transportation was by district owned bus or carry-all. Cost per mile of district vehicles for 1966-67 was about 41½ cents per mile. This includes driver salary, maintenance, fuel, insurance, and depreciation. It is estimated 1967-68 costs will approach 45 cents per mile.

The one child transported by taxi to a class in Urbana resulted in a total cost of $520.10 for the year. Distance involved was about six miles round trip for 176 days or almost $3.00 a day. While the per mile cost is not significantly higher, it must be remembered the number of children transported by the district vehicles is significantly higher than the capability of the taxi. The taxi, however, can't be overlooked for the single case or two in remote areas not covered by regular routings.

As one final item to consider, it is important to call your attention to H. B. 1445 passed by the 75th General Assembly. Basically, H. B. 1445 allows school districts to transport handicapped children to non-public facilities and receive 80 percent reimbursement of cost. This is a permissive, not a mandatory law. The initial interpretation is that no regulations will be circulated on this act this school year. If the district deems the child is receiving an educational service at the facility, they may transport and claim reimbursement.

In general, it would appear if a district vehicle is in the vicinity and has space available the chances of transporting the child would be good. It does not appear school districts would add to their present transportation systems to provide this service. The best approach would be to request the service from your school district. It would not appear wise to demand the service since the law is permissive.

Transportation methods, problems, and costs will vary greatly in each community. This paper has attempted to illustrate these concerns based on a school district operation with some possible suggestions to assist you in planning and operating transportation services for the retarded.

## REFERENCE

*Newsletter.* **Springfield, Illinois: Office of the Superintendent of Public Instruction, August, 1967.**

# PROGRAM PLANNING

# BASIC CONSIDERATIONS IN DEVELOPING COMMUNITY SERVICES FOR THE MENTALLY RETARDED

Charles E. Beck, M.D.
and
William K. Murphy, M.S.W.

In October, 1962, when the late President Kennedy's panel on mental retardation submitted its report, *A Proposed Program for National Action to Combat Mental Retardation,* a major national health, social, and economic problem was brought into full view. With increasing public awareness and understanding of mental retardation, most states are actively planning and implementing programs for comprehensive care including research, training, and direct service delivery. Emerging programs are often actualized by the use of numerous Federal grant programs.

In Illinois, there has been a continuing improvement and expansion of state residential care facilities with emphasis placed on the development of small specialized units. Public school education classes, community day centers, diagnostic services, and other resources have developed to meet the needs of the retarded. While it may seem that we are well on the way to meeting the needs of the retarded, few, if any, major problems have been solved. We are still faced with a shortage of manpower, a lack of comprehensive community-based services, inadequate planning and coordination of services, and limited funding. We should not oversell our few accomplishments at the risk of falling far short of our goals. In this context let us consider together some of the basic considerations in developing community services for the mentally retarded.

## Basic Considerations

Mental retardation is defined as "subaverage intellectual functioning associated with an impairment in adaptive behavior" (AAMD, 1962). Within this definition is found a broad range of persons, from those with slight impairment to those with a profound handicap. All of these classes of people can be helped. Recent studies have demonstrated that even the profoundly retarded can learn such self-help skills as toileting, feeding, dressing, and bathing. Each person must be helped to learn, to adapt, and to develop to his maximum capacity.

Various estimates have been used to determine the incidence of

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mental retardation in the United States. The President's Panel (1962) estimated that three percent of the population, or 5.4 million children and adults afflicted with mental retardation. It is further estimated that 95 percent of all of the retarded are in the combined mild and moderate categories with the remaining 5 percent in the severe and profound groups. A broad range of rehabilitation and prevention programs are needed to help these people lead useful and satisfying lives and to reduce the incidence of mental retardation. The program should be implemented with as little dislocation from a normal environment as is consistent with the special needs of the individual. In other words, service should be as close to home as possible and delivered in such a way as to maintain the relationship of the individual with his peers and family. It is on this philosophical base that we emphasize the need for community-based service for the mentally retarded.

## Planning and Coordination

Fundamental to the development of effective community services for the mentally retarded is the need for planning and coordination of programs. Much effort has been put into planning and coordination at the Federal and state levels. In Illinois, state and regional structures for general planning and coordination have been established, and various communities and organizations have addressed themselves to the problem. In spite of this significant effort, progesss has been exceedingly slow due to limited data, ever changing needs in, and inadequacies of planning methodology. New programs are still developing in a vacuum. Community planning agencies are sometimes ignored or lack real interest in becoming involved with mental retardation.

In developing service, we must view the retarded person as a part of, rather than apart from his fellow citizens, sharing the same basic needs. Our society has created the family, the professions and health, education, and welfare agencies to meet these needs. All too often, however, the retarded person is left out, excluded from important services.

## Generic Service

The general or generic agency was defined by Jaslow, (1967, p.5), as "any health, welfare, educational, rehabilitative, or employment agency in the community whose purpose is not for the specific care of the mentally retarded. An example might be an orthopedic clinic not specifically for the mentally retarded which would be considered a specialized resource in other circumstances." A basic consideration in developing community service for the mentally retarded is the appropriate use of every generic community agency. Most of the lifetime services required can and should be provided by existing agencies. For example, in planning services for the retarded, we often speak of such "specialized" programs as home nursing, foster care, homemaker service, family counseling, diagnostic and evaluation service, social clubs, vocational training, recreation and leisure time activities, to mention only a few. Yet, these very services are often available in most communities and need not be redeveloped as a special service for the mentally retarded under the auspices of a new organization or program.

It may require effort, however, to extend the services of generic agencies to the mentally retarded, but planning and coordination efforts at the community and regional level must be directed to this goal. When this is accomplished, more community services will be available to the retarded; whereas, if we focus only on the development of specialized agencies, we will only further isolate the retarded. For example, the Department of Mental Health frequently is viewed as the agency which has total responsibility for care of the retarded, and therefore, often receives referral from both public and private agencies requesting services which those agencies could themselves provide. Other examples of this tendency for generic agencies to refuse services to the retarded when it is perceived that a specialized agency exists could be cited. Should not a public or private child-placing agency charged with the responsibility to plan for dependent and neglected children provide service to the child who is dependent, neglected, and also mentally retarded?

The primary consideration in meeting the needs of the mentally retarded is the appropriate use of every generic community agency. Secondarily, a limited number of specialized agencies will be required in order to provide the broad array of service required at the community level. The role of the specialized agency, however, must be defined clearly to avoid confusion and inappropriate referrals. Specialists of mental retardation must be used appropriately in order for the community and those requiring service to receive maximum benefit. Some of the specialized services available in Zone V are described below.

## Specialized Services

A community day center in Sangamon County provides services to mentally retarded children, adolescents, and adults. Retarded persons served in this program live at home and attend the day center approximately 5 hours per day, excluding weekends. The center offers training-activity experiences in such areas as self-care skills, safety, and oral language. This program is designed to serve primarily preschool retardates at all levels of retardation, school age retardates ineligible for public school special education classes, and post-school retardates unable to benefit from formal vocational training. Such specialized programs are of prime importance in maintaining certain mentally retarded children and adults in the community.

Another example of a specialized program is the short-term inpatient training program for retarded children at the MacFarland Zone Center. The purpose of the short-term inpatient training program is to provide retarded children with a systematic habit-training program which: (1) leads to the development of various skills in meeting their own personal needs such as toileting, feeding, dressing and undressing, and bathing; (2) reduces home and community management problems; and (3) reduces the need for state residential care.

This inpatient service provides short-term intensive training in which specific methods and techniques are developed for an individual child in such areas as toileting, feeding, dressing and undressing, and bathing. The mother of each child is encouraged to participate on a daily basis in the training program whenever possible, learning the specific techniques so she can continue the training program at home. If the child's mother is not available, someone else directly involved in the child's home care participates in the program. The mother's participation is flexible in that it depends on the nature of the child's condition and the family situation. Some mothers are asked to participate directly in the training program at the time of admission and immediately prior to dismissal. In all cases, the family is involved in a pre-care and after-care program. If commuting distance is a problem for the mother, arrangements can be made for her to live in the same unit with the child. Participation of the mother is viewed as an important aspect of the training program.

In the area of pre-care service, it should be emphasized that program staff are available to work with families and/or other agency staff prior to the child's admission to the program. Also, staff will not divorce themselves from the after-care program. Emphasis, however, is placed on involving staff of various agencies in the community. For example, a county public health nurse may be active in a case and would need to be involved in pre-care services, inpatient training program, and after-care services. Here, we would be involving the services of various generic agencies.

The preceding discussion provides two examples of specialized services required in the full complement of services essential to meet the needs of the mentally retarded.

## Future Planning

While we are beginning to recognize the needs of the retarded and are formulating ways of meeting these needs on many levels, our future hope for real progress must include effective work in the area of primary prevention. It has been estimated that between 15 and 25 percent of all cases of mental retardation are caused by some specific disease entity. These are classified by the American Association on Mental Deficiency (1962) in such groups as infectious childhood diseases, metabolic disorders, disease due to physical and traumatic damage, toxic agents affecting the mother and child, infection of the mother during pregnancy, genetic or hereditary problems, and other diseases of unknown origin.

In recent years, medical progress has reduced significantly the incidence of infectious illness by active treatment and preventive immunization. Improvement of obstetrical care of expectant mothers and in the management of the newborn is continuing. Early detection and treatment of certain metabolic disorders such as phenylketonuria and galactosemia are now possible. Continued research may reveal yet other conditions amenable to treatment. Significant contributions in the area of genetics have led to explanations for certain types of mental retardation. Knowledge now allows us to predict with considerable precision the probable reoccurrence of a condition within a family, and it is possible that future developments will allow modification of genes in such a way as to prevent retardation.

It is not suggested that the community set back and complacently wait for a medical discovery to solve the problem. Existing knowledge already links deprivation in early life, parental neglect, child abuse, lack of intellectual stimulation in the home, and other environmental factors to the incidence of mental retardation, particularly in the milder categories. Efforts to protect children from such negative experiences should extend far beyond the realm of the agencies previously discussed and become the responsibility of the people or citizens within the community. The incidence of mental retardation and mental illness is significantly higher in the low social-economic areas so that efforts to eliminate poverty and its concomitants should be encouraged.

## Summary

Provision of adequate services for the mentally retarded is a community responsibility which should be shared primarily by existing generic agencies and secondarily accomplished by development of specialized services when necessary. Programs within Zone V are being developed in accordance with this philosophy. A special advisory council has been formed from a group of interested citizens to help develop and monitor plans for the implementation of effective services for the retarded and for the families of retarded children. The Zone Center serves as a primary referral point for applicants for residential care. Screening of these applicants will be accomplished in collaboration with existing care-giving agencies within the Zone. There has been preliminary discussion of plans to include certain metabolic studies and/or chromosomal studies at some point in this process.

Much that remains to be done can be accomplished only with continued community encouragement, support, and effort in behalf of the mentally retarded.

## REFERENCES

American Association on Mental Deficiency. *A Manual on Terminology and Classification.* Monograph Supplement to the *American Journal of Mental Deficiency,* 1962.

Jaslow, R. *A Modern Plan for Modern Services to the Mentally Retarded.* Washington, D.C. U. S. Department of Health, Education, and Welfare, 1967.

Presidents Panel on Mental Retardation. *National Action to Combat Mental Retardation.* Washington, D.C. Government Printing Office, 1962.

# PLANNING LOCAL SERVICES AND PROGRAMS FOR THE MENTALLY RETARDED

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Planning is a complex, perpetual process. It is a means for effecting systematic, integrated changes in pursuance of efficaciously and economically attaining realizable goals. Planning, in combination with evaluation, ultimately influences the course of action, the media of implementation, and, in some instances, the goals themselves.

Today, we in Illinois are at a new stage in planning and developing programs for the mentally retarded. During the past two years, based on the recommendations of the State Advisory Council as contained in *Patterns for Planning* (1965), efforts have been made to examine existing programs for the retardate on a State and zone level. Dramatic changes also have occurred with respect to programming as it relates to mandatory education (House Bill 1407) and activities of the Department of Mental Health's zone programs. The net effect of these accomplishments has been to increase the need for planning on a subzone level. Subsequently, the purpose of this discussion is to consider the planning process in relation to providing comprehensive services for the mentally retarded on a subzone basis.

### Comprehensive Programs for the Retarded

Prior to discussing some of the planning needs as they relate to subzones, it is advisable to review the ultimate goals and objectives of programming for the retarded. These goals were expressed originally by the President's Panel on Mental Retardation in 1962 in its concept of a "continuum of care." Though the term has become somewhat of a cliche, its meaning has not:

> "Continuum of care" describes the selection, blending and use, in proper sequence and relationship, of the medical, educational, and social services required by a retarded person to minimize his disability at every point in his life span. Thus, "care" is used in its broadest sense and the word "continuum" underscores the many transitions and liaisons, within and among uderscores the many transitions and liaisons, within and among various services and professions, by which the community attempts to sercure for the retarded the kind and variety of help and accommodation he requires. A "continuum of care" permits

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> fluidity of movement of the individual from one type of service to another while maintaining a sharp focus on his unique requirements. The ongoing process of assuring that an individual receives the services he needs when he needs them and in the amount and variety he requires is the essence of planning and coordination (President's Panel, p. 74).

Furthermore, the President's Panel (1962, p. 15) lent guidance to the development implementation of such programs in the following four recommendations:

> 1. That programs for the retarded, including modern day care, recreation, residential services, and ample educational and vocational opportunities, be comprehensive.
> 2. That they operate in or close to the communities where the retarded live—that is, that they be community-centered.
> 3. That services be so organized as to provide a central or fixed point for the guidance, assistance, and protection of retarded persons if and when needed, and to assure a sufficient array or continuum of services to meet differet types of needs.
> 4. That private agencies as well as public agencies at local, state, and federal levels continue to provide resources and to increase them for this worthy purpose.

Both the concept of "continuum of care" and the President's Panel's four-point approach are endorsed highly by the Governor's Interdepartmental Committee on Mental Retardation and the Illinois Department of Mental Health (Visotsky, 1968).

Specific programs associated with the "continuum-of-care" concept have been defined by both the American Association on Mental Deficiency and the National Association for Retarded Children. The 19-point program advanced by the American Association on Mental Deficiency includes: (1) diagnosis; (2) parent counseling; (3) day centers; (4) short-term residential care; (5) long-term supervision and guidance; (6) case finding; (7) home training; (8) nursery classes; (9) special education; (10) adult education; (11) vocational training; (12) sheltered workshop; (13) custodial day care; (14) long-term institutional care; (15) foster home, halfway house; (16) recreation; (17) research; (18) training of personnel; and (19) public education (Gardner and Nisonger, 1962).

### Subzones

In 1961, the State was divided into eight mental health zones for the purpose of implementing effective programs. Recently, two zones (II and III) were combined into one *Metrozone* area, which includes Chicago and the surrounding counties. Subzone planning areas were developed as a logical extension of the decentralization concept which was the basis for dividing the State originally into eight zones. While the zones serve as appropriate administrative units, they are too large for planning community-based services; hence, further division of the zones into smaller units provides a realistic basis for the establishment of community programs in mental retardation facilities.

There are 75 subzone planning areas in the State, of which 27 are in the City of Chicago. Recently, the 27 subzones were additionally grouped into 15 subzones for programming purposes. The original determination of subzone planning areas was based primarily on population; that is, subzone areas, except in rare instances, consisted of populations ranging between 75,000 and 200,000 persons. The subzone planning areas in downstate communities consist of aggregates of counties; in the Chicago suburban area, aggregates of townships; and in Chicago itself, aggregates of community areas. In every case, an effort was made to aggregate either counties, townships, or community areas which have a history of cooperative effort in the health and welfare field. Further, in each of the subzone areas a hub city was selected. A hub city is an urban complex, located on the main transportation route, which serves as a logical and convenient location for a community center serving a subzone area. The issue of the hub center did not arise, obviously, in the City of Chicago.*

### Planning in Subzone Areas

As mentioned, the population associated with each planning area is approximately 75,000 to 200,000. In order to plan effectively for the subzones, it will be necessary to estimate the number of retarded to be served, their needs, and available resources and programs. Subsequently, it is hoped that priorities will be established as they pertain to the development of absent but required services. Consideration also should ge given to means for developing such services. For example: Are there available community resources which could expand their programs to include the retarded? Are generic services being used adequately? Is legislation required?

It is expected that for each subzone there be a cental point of referral, provisions for short-term residential respite care, and at least one homemaker. For every 100,000 population, it is estimated that there will be a need for at least 40 public school classes to serve approximately 600 educable retarded; 7 classes to serve approximately 68 trainable retarded; one day center to serve approximately 60 retardates of all ages who are otherwise school-ineligible; and a sheltered workshop/ vocational training program to accommodate 200-300 adolescent and adult retardates. Furthermore, it is desired that there be some facility offering social-recreational experiences for approximately 200 retarded adults. Recreation programs should be available to the retarded on a broad community basis, and special recreation programs should be developed for approximately 60 moderately, severely, and profoundly retarded.

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* A complete listing of the planning areas can be found in Scheerenberger and Wagner (1968).

The Zone Advisory Councils are requested, and expected, to examine retardation programming on a subzonal basis. While it is not the Zone Advisory Council's function to provide initial data, which will be furnished by the general offices of the code departments as well as their regional representatives, it is the responsibility of the Zone Advisory Councils to plan, evaluate, and make recommendations:

> The zone council will have primary responsibility for evaluating efforts to implement the comprehensive state plan as it affects its zone; evaluating existing programs for the mentally retarded; presenting recommendations for modifications or additions to existing programs or new programs within its region. The zone council is to be concerned with all programs for the retarded in the zone. Its concern is not to be limited to any one program or agency, but rather is general. Its recommendations will stem from its review of the total zone program and will not be mandatory but advisory to any specific agency (Patterns for Planning, 1965, p. 83).

In essence, it is desired that the Zone Advisory Councils, in collaboration with representatives of State and local agencies, accomplish the following six tasks during the forthcoming year:

1. Determine local needs as they affect comprehensive services for the retarded;
2. Determine available local resources (generic and specific);
3. Establish a local service priority on the basis of need minus resources, taking into consideration realistic, attainable goals;
4. Determine effective means to attain priority services;
5. Consider subzonal needs within the spectrum of total zone and State planning;
6. Make recommendations to the Interdepartmental Committee on Mental Retardation concerning state-level policies, procedures, or legislation required to effect better programming.

While subzone planning seems complex, it need not be. Members of the Zone Advisory Councils were selected and appointed on the basis of their interest and knowledge of their area and of the needs of the retarded. A collaborative effort between Zone Advisory Councils, representatives of State agencies, and local persons should produce desired results with a minimum of effort. Zone staff of the Department of Mental Health should be contacted frequently in assessing needs, resources, and priorities. Also, agencies serving multiply handicapped persons should be involved with planning — frequently, an effective program will require joint effort on the part of several organizations.

### Forces in Planning and Evaluation

The emphasis of this presentation has been on subzonal planning conducted primarily by the Zone Advisory Councils on Mental Retardation in collaboration with local agencies. This emphasis on planning and implementation at the local level does not, however, imply any desirability for isolation. There must be a constant dialogue and interchange of ideas at all levels of effort — community, county, subzone, zonal, state, and Federal. Though there are unique characteristics in local communities with respect to populations to be served, available resources, community support, and priorities, the basic goals of programming for the retarded and their families are relatively universal.

Some of the problems encountered by the community may not be resolvable at a local level. To illustrate, State grant-in-aid is essential to program development, as is Federal financing of construction and staffing. Each local community needs to be alert to what is transpiring at State and Federal levels as does State and Federal personnel need to be familiar with local problems. In essence, isolated planning or programming by isolated groups cannot accomplish the job adequately.

### Summary

The State of Illinois, in its efforts to meet the programmatic requirements of the retarded and their families, has progressed from a general statement of intent and state-wide descriptions of needs and available resources to the point of recognizing the challenge of programming at local and subzonal levels. This paper briefly discussed some of the major areas and components associated with planning such programs. Though major responsibility for this task has been delegated by the Governor to the Zone Advisory Councils on Mental Retardation, the task can be accomplished only through a continuous dialogue between representatives of agencies and organizations interested in the mentally retarded at all levels of participation.

### REFERENCES

Gardner, W. I., and Nisonger, H. W. *A Manual on Program Development in Mental Retardation.* Monograph Supplement to the *American Journal of Mental Deficiency,* 1962.

*Patterns for Planning.* Springfield, Illinois: Department of Mental Health, 1965.

President's Panel on Mental Retardation. *National Action to Combat Mental Retardation.* Washington, D.C.: Government Printing Office, 1962.

Scheerenberger, R. C., and Wagner, R. L. *Day Programs and Residential Facilities for the Mentally Retarded.* Springfield, Illinois: Department of Mental Health, 1968.

Visotsky, H. M. Department of Mental Health and Mental Retardation, *Mental Retardation in Illinois* 2(3): 35-39, 1968.

# PROGRAMMING AND THE METROPOLITAN PUBLIC SCHOOLS

Bernice G. Goodwin

The mentally retarded are those persons who, from birth or childhood, have impaired intelligence as well as varying degrees of difficulty in meeting demands of daily living. Identification of the mentally retarded child may be made through one or more avenues, with some adult initially observing that "this child is different." Far too often the difference is tolerated or overlooked, leading to complications and an increase of behavioral problems. The majority of the mentally retarded are in the educable mentally handicapped category and are usually not identified until they are in school. The bulk of such children are not diagnosed as mentally handicapped until they come to grips with the demands of academic learning.

## The School and Community

This child who is different is referred in the Chicago Public Schools to one or more of the diagnostic processes, e.g., psychological, educational, and medical. After diagnoses, what? Today, in large school systems we find a cross section of services made available to the mentally retarded child or youth. In general, however, school services are still relatively isolated from each other, with few or no established plans or techniques for interpreting or correlating data relevant to meeting the child's needs or improving his adjustment to school, home, or community.

Other agencies and disciplines face the same problems as does the metropolitan school system: an appalling lack of trained workers and adequate facilities. If we are to intensify the attack on mental retardation on all fronts — prevention, treatment, education, rehabilitation, employment, and recreation — we must begin now. We must work towards increasing the availability and quality of staff as well as physical facilities required to meet the known and unknown needs of the mentally retarded.

It is significantly important for all pupil personnel that the school-community-agency concept be initiated and fostered. This globular approach is especially needed for the mentally retarded. This will require a great deal of "give and take" on the part of each of us, as

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well as of the community agency or service we represent. Community agency personnel and school personnel far too frequently interact defensively and negatively when they share a common concern for a child, especially if he is handicapped.

Agencies need to develop a sincere appreciation of what "others" are doing for the same child. Further, they should give thought, followed by endeavor, to furthering the betterment of the mentally retarded by continued planning together. Only in this way will agencies thoroughly recognize existing inter-relationships or common concerns for the mentally retarded. The alliance of community and school services cannot be denied or ignored.

Just as there must be continuity of planning and programming for the school-community-agency concept, the schools themselves must plan and program for the needs of the mentally retarded. Placing a child in a special education program does not relieve regular school personnel from responsibility. Special education is not a program of convenience. It is tailored to meet the special needs of the child who is significantly different in one or more ways.

The principal of a school retains and must shoulder responsibility for all that goes on within the school. As pupil population grows, with a corresponding growth in diversity of pupil personnel, the principal usually delegates specialized tasks, such as interpreting special education, to others. The supervisor of special classes, the psychologist, the adjustment teacher or counselor, the teacher-nurse, and the social worker may work individually with the parent or community agency. The better plan, however, is to have two or more of the above-mentioned personnel actively staffing the case.

School and community personnel who work with the greatest success recognize that you cannot work with any client, be he child or adult, in a vacuum. They know that the deepest roots of a child are in the home. They have become increasingly aware that bringing about a change in a child is a complicated process, and that change takes place only when all persons concerned are involved and interacting.

Here you see a definite charge to each community agency to get to know and respect each other as colleagues with competencies. We need to understand and employ these competencies to their fullest degree to serve the child and his family in the most effective way.

## Collaborative Programs

In March, 1967, President Johnson, in a Special Message to Congress on Children and Youth, stated that the task is to *marshall* all services pertinent to children's needs and to develop within our comprehensive neighborhood centers a "single door" through which a child and parent can enter to obtain the needed help.

It is interesting to note that all projects sponsored by the Elementary and Secondary Education Act (ESEA) under Titles I, II, and VI carry a mandate to be both exemplary and innovative in nature. Projects under Titles I and VI require that school personnel have understanding in depth of child needs in relation to his total environment and that involvement of community agencies be implicit to any project planning. These mandates are directed toward the goal of the "single door" policy. School personnel working with ESEA projects are becoming more sophisticated in their knowledge of the "when," "where," and "how" of working with community agency personnel.

For example, the Child-Parent Education Centers in Chicago reportedly are having much success in working with community agencies. These Child-Parent Education Centers, which are ESEA funded, involve children and parents in cooperative educational programs. Children, ages three to five years, including some mentally retarded, attend half-day sessions in classes using the team approach. The professional team includes a master teacher, an assistant teacher, an health aide, a school-community representative, a speech teacher, and a teacher-nurse. Parents attend class at least one-half day a week and are being stimulated through discussion and demonstration to improve their relationships with their children, and to learn how to locate and use community agency services. Reports, both objective and subjective, appear to indicate that professional staffs of the school and agencies are doing exceedingly fine work, not only in the area of increasing sensitivity to the child and his family but also to each other as members of a team sharing similar goals and responsibilities.

A report in November, 1966, by the National Advisory Council on Summer Education for Children of Poverty to the President of the United States contained findings which are significantly applicable to the education of the mentally retarded and to the growing community consciousness of the need for cooperation of all individuals and agencies concerned with children. The findings indicated that summer projects, though causing teachers and administrators to focus new thinking on ways to overcome educational deprivation, were, in the main, too fragmented or too vaguely directed. A few comprehensive programs were strategically planned for bringing about pupil change. These latter programs were based on four essential needs, namely: (1) adapting the academic content to the special problems of the disadvaantaged child; (2) improving in-service training of teachers; (3) providing for nutritional and other health needs of the child; and (4) involving parents and community agencies in the planning and assessing of school programs. Again, we see the challenge of involvement and concern of trained personnel of many disciplines in resolving the problems of one child and his family.

Our metropolitan services for children and families are many — some exceedingly imaginative and innovative, while others remain static and patent — but all are to fragmented. Their approach and contact with the child gives little or no recognition to the child as a total functioning being. Planning an educational program for the total child in any community is an overwhelming task. Another dimension is added to the task when the child is handicapped. The Illinois Legislature, with House Bill 1407, took a dramatic and giant step towards eliminating conditions which dim and narrow the promise of life to handicapped children.

The Chicago Plan for Organization and Administration of Special Education to Implement House Bill 1407 is awesome in its magnitude and challenge. It was difficult to establish priorities because of the need for a broad frontal attack on all problems affecting the handicapped, especially the mentally retarded. Our Chicago planning had to zero-in on an estimated school population of 900,000, including public, private, and parochial schools. As of September, 1967, the actual population of the Chicago Public Schools was 570,000, with an estimated additional population of 50,000, made up of children and youth between the ages of three to five years and sixteen to twenty-one years, respectively, plus an in-migrant population. Chicago's social and economic levels run the gamut, with predominance of the low socioeconomic groups in the school population. Our current services provide for more than 9,000 pupils in 650 EMH classes and 50 TMH classes. Our anticipated needs, based on population studies, rather than population planning, indicate the need for an optimum of 1,200 EMH classes and 120 TMH classes. The low-incidence categories for the mentally handicapped in a large metropolitan center, such as Chicago, is to be found in the areas of the multiply-handicapped EMH and TMH groups. The major militating factor against immediate service for the low-incidence categories is the lack of trained personnel.

You can readily see what demands school services of such proportion mean to community agencies and allied disciplines. If a global approach to meeting the needs of the mentally retarded is to be realized, schools cannot stand aloof or as an entity unto themselves. They must look to research and clinical centers for new knowledge pertinent to those they serve, as well as for solution of their manpower problems.

We must increase our tempo in the development of community-based services. The Chicago Schools in their new administrative organization gave impetus to meeting the need for community-based services with the establishment of three relatively autonomous Administrative Areas. These three administrative units will be geared to the immediate and projected needs of their clientele. Each Area Associate Superintendent will plan the short- and long-range building program for his particular area, as well as new and creative springboards for educating Chicago's children and youth. The Proposed Cultural Educational Centers and Magnet Schools are evidences of springboards toward improving the quality and content of educational programs.

Any or all of the above new directions will have a positive effect on Chicago's programs for the mentally retarded. Much more must be done in the areas of prevention and treatment and in understanding the mentally retarded child in all phases of his development. During the last decade, much has been learned in these areas — but how much has been applied and evaluated? As we grow in our understanding of children in general, we hopefully should see a proportionate growth in understanding and serving the mentally retarded.

### Professional Training Needs

I believe that all behavioral disciplines should include in their training programs some background knowledge and experience in working with the mentally retarded. In addition, medical schools, especially in their training of primary physicians, should require some internship with the mentally retarded; the related field of nursing should likewise provide for such training. Programs such as these have been initiated in some medical and nursing schools.

Clinics geared for the mentally retarded afford excellent training grounds for such personnel as psychologists, medical workers of all types, counselors, and social workers.

Professional training for workers in mental health, in vocational rehabilitation, in public aid and health, in teacher training, in psychology, in labor, and in innumerable other areas of professional competencies should have, as part of their training, exposure to and basic training with that segment of our citizenry known as the mentally retarded.

As knowledge of the mentally retarded grows among the various disciplines, new categories of professional workers will emerge. These new professionals may, in a sense, be liaison workers competent in meshing community programs toward the end of bringing new insights into services for the mentally retarded child and his family. In so doing, we, in our individual and related endeavors with the mentally retarded, will have contributed to promoting a more humanitarian approach to the manifold problems of mankind.

## REFERENCES

National Advisory Council on Summer Education for Children of Poverty. *Report of the National Advisory Council on Education of Disadvantaged Children.* Washington, D.C.: U. S. Department of Health, Education and Welfare, 1966.

# THE NEEDS OF THE MENTALLY RETARDED IN RURAL SETTINGS

Albert J. Shafter, Ph. D.

In a limited sense, the answer to the question contained in the title of this paper could be completed in a single sentence: The retarded in rural areas have the same needs as other retarded persons, or indeed the needs of all human beings. What is unique, however, is that the needs of the retarded in rural areas are largely unmet. It generally is recognized that relatively few resources and services exist for mentally retarded persons in rural areas and small cities. This is particularly true of southern Illinois. It remains meaningful to state (Shafter and Renzaglia, 1961, p. 1):

> This condition has existed largely because the area lacks economic and industrial opportunities for employment affecting not only the disabled but the "able" as well. Public attitude has generally been passive and apathetic, and, as a consequence, service for the severely disabled has been restricted to some form of maintenance or custodial welfare assistance. Moreover, in an area of dispersed population where an over-all coordination of welfare and rehabilitation activities was nonexistent, the severely disabled have been relegated to relative obscurity, perhaps akin to the hope that if ignored the problem might disappear.

It will not be the purpose of this paper to be concerned with an effort to list the unmet needs of the retarded but rather to discuss two areas affecting the unmet needs of the retarded in rural areas: (1) attitudes of parents of retarded in rural areas, and (2) broad obstacles to program planning.

## Family Attitudes

The early notion of agricultural fundamentalism developed a mythology that social ills, and by inference, mental retardation and mental illness, were a product of urban life. An analysis of first admissions to Iowa institutions for the retarded in 1920 revealed the proportion of first admissions was roughly the reverse of the rural-urban distribution, i. e., while Iowa was approximately 80 percent rural, about 80 percent of the first admissions were from urban areas. By 1940, however, 44.6 percent of Iowa's urban while 68.9 percent of the first admissions came from those areas (Shafter and Coe, 1956). A more detailed

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responsibility for developing and implementing programs for the retarded in rural areas.

Another crucial problem is to determine who is responsible for extension of services to the retarded in rural areas. It should be noted that no agency has responsibility for rehabilitation (in its broadest sense) of the retarded and severely disabled. The one exception is the public school who will have responsibility for the moderately and mildly retarded from ages 5 to 21.

In large metropolitan areas where there is adequate financing, private welfare agencies provide services for such individuals. Thus, lighthouses for the blind, cerebral palsy associations, parent groups, special interest groups such as Jewish Vocational Service, have initiated and demonstrated the feasibility of day care centers, sheltered workshops, etc. It is obvious such groups are either nonexistent or relatively weak in areas characterized by a dispersed population and a depressed economic condition. At best, their efforts are intermittent and subject to change at all times. For example, whether a day care camp for the retarded will continue or disappear may depend upon a single dedicated individual. Until the problems of leadership responsibility have been resolved, services for rural areas will remain inadequate.

Finally, a relatively new concept has been developed to provide an explanation for the lack of services for the retarded in rural areas. This is the pleasant fiction that the development of resources for the retarded is a community responsibility. Such an idea makes sense in densely concentrated areas of population with adequate levels of employment. However, in at least one mental health sub-zone in Illinois, three of the six counties have as their largest town the county seat, each of which has less than 1,000 population. In some of these counties unemployment is over 20 percent of the working force. It should be obvious that resources for the retarded will not be developed without leadership and financing from outside agencies or organizations. Unless this elementary fact is recognized, similar conferences will be held, pious good wishes will be exchanged, and yet another paper can be presented regarding the unmet needs of the retarded in rural areas.

## Conclusions

To conclude, a need exists for fresh and flexible approaches to developing programs for the retarded in rural areas. The assumptions and beliefs we hold regarding established programs in urban areas must be looked at in a critical light to determine whether they should be modified to reach the retarded in rural areas. Consideration must also be given to how recommendations can be implemented. It is to be hoped this conference will face the task.

## REFERENCES

Shafter, A. J., and Fraenkel, W. A., Services to mentally retarded children and youth in rural areas. In: Burchard, L. B. (ed.). *Rural Youth in Crisis.* Washington: U.S. Department of Health, Education and Welfare, 1965.

Komisar, D. D. Key political and cultural factors influencing services for the retarded in western Europe and the United States. In: D. Michael, S. G. (ed.). *New Vocational Pathways for the Mentally Retarded.* Washington: Personnel and Guidance Association, 1966.

Shafter, A. J., and Coe, R. M. Administrative planning and population forecasting. *American Journal of Mental Deficiency,* 61: 337-340, 1956.

Shafter, A. J., and Kendel, W. F. The predictive value of the concept familism. *Alpha Kappa Delta,* 1: 36-38, 1959.

Shafter, A. J. and Renzaglia, G. A. *A Survey and Recommendation for the Disabled of Southern Illinois.* Carbondale: Southern Illinois University Area Services, 1962.

# PRINCIPLES IN RURAL PLANNING FOR THE RETARDED

Victor P. Wenzell, Ph.D.

The intent of this presentation is to outline the distinguishable ingredients in meaningful planning and organizational structure for mentally retarded children and adults residing in rural settings. The problem simply stated, is: "How can we best provide and coordinate the array of necessary services for the mentally retarded in rural areas—services that must be at least equal to the best being developed in metropolitan areas?"

The existing arrangements for coordinating health, education, and social services in sparsely populated areas preclude the provision for pervasive programs for the retarded. Vast geographic areas, scattered population, and a proportionately low prevalence of children and adults who are mentally retarded, become serious obstacles to providing specialized personnel and facilities accessible to those in need (Jordan, 1966).

## Principles

A primary challenge of coordination is to provide the resources and services and integrate them into a balanced, comprehensive program of treatment, training, and counseling. The most critical need, however, is to bring this array of services within easy reach of all the retarded and their families at the time they are most needed. Principles in rural planning for the retarded must have a built-in quality of being both integrated and uninterrupted (President's Panel on Mental Retardation, 1962).

If coordinated services are to be developed, six broad principles in rural planning for the retarded assume overriding importance.

*Principle one.* The greater the degree of sparsity of mentally retarded individuals in a given geographic area, the greater the need for the development of state level direction, coordination, and financing. It would be most fortunate if the mentally retarded population confined itself to existing political boundaries on a constant ratio-to-general population basis. Such is not the case.

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Hurder (1962) listed three conditions for coordination of services of the type needed by the retarded: *communication, cooperation,* and *authority*. It is absolutely essential that all participants in an enterprise as complex and diversified as total planning for the retarded in the health, education, and social fields have, and use, adequate means for communicating objectives and activities.

Cooperation is a learned behavior and is susceptible to intelligent direction. The "cooperants" must have broad needs and objectives in common, and each must have some needed resource to contribute to the common development of the array of services. Participants in cooperative services get more for their pooled energies than if each worked alone. Cooperation reduces cost and assures availability of help when and where the retarded need it. Authority from a central source will not assure coordinated effort but it will, hopefully, give direction and purpose without needless duplication of effort or funds.

*Principle two*: Any organizational framework utilized in planning and executing services for the retarded living in rural areas is nothing more than a vehicle which permits program development. There is no inherent value in any one line-staff structure but it is of immense importance that such structure be flexible and have an open-ended quality.

The problems of providing comprehensive services to the retarded are mainly administrative in character. Identification, admission to services, and referral of the retarded, the hiring of specialized staff, transportation, and the determination of program components are basic to any plan but are paramount issues in an area which is sparsely populated (Melcher and Blessing, 1957).

In most cases, leadership personnel already available in rural areas in the health, education, and social services have had little previous structured contact with the mentally retarded or their families. Consultation or direction has frequently suffered from lack of a multidisciplined approach and from the stimulation that derives from "role blurring" among the disciplines. Evidence suggests that state efforts to meet "continuum of care" needs of the retarded aim at increased quantity, rather than the quality offered by a coordinated array of services. Too often, the pleas of necessity and temporary advantages are utilized to solve rural area problems on a short-term basis.

The 1958 Conference of the Council of State Governments cautioned that "the problems of the mentally retarded are not and cannot be the responsibility of any one department of State government." Furthermore, "each State should make arrangements through such means as an interdepartmental committee, council, or board for the joint planning and coordination of State services for the mentally retarded" (The President's Panel on Mental Retardation, 1962). Improved cooperation within and between existing State and local agencies does not necessitate the creation of a new agency with "overlord" responsibilities for the rural mentally retarded.

*Principle three:* Where modifications in state and local structure of services is necessary, legislative action may be required. One should not hesitate to seek such changes if they will facilitate effective programming or administration.

*Principle four:* Administrative patterns for developing services to the retarded in sparsely populated areas should be designed in such a way that they incorporate, or at least operate harmoniously with existing health, education, and social services at the local level.

Often, rural communities need to become aware of the presence of the retarded in their midst. Rural communities — including the general population as well as staffs of existing supportive agencies — also need to become acquainted with available resources and their use (Annas, 1959). Rural communities tend to think in terms of public school services, or when these are lacking, to institutionalization as the only avenues open to the treatment, training, and counseling of the retarded.

A most promising development in the mechanics of bringing services to the retarded and their families is the "fixed point of information and referral concept" (President's Panel on Mental Retardation, 1962).

*Principle five:* Much of the needed planning thrust derives from forces other than an existing internal coordinative-administrative structure. Private organizations (religious, cultural, or philanthropic) parent groups, fraternal societies, and legislators must be mobilized and become an integral part of any plan. Providing direction to these forces requires extraordinary professional leadership.

*Principle six:* Adequate and appropriate services for the rural retarded are high-cost programs in terms of financial outlay. Three specific ingredients for financial support of rural services are evident: (1) Excess cost formulas are necessary and should be administered so that the problem of sparsely populated areas is recognized. (2) Local incentive must be encouraged by matching local with state funds. (3) State assistance should be offered for capital outlay as well as operating costs.

## Conclusion

Applying the foregoing principles in rural planning for the retarded will most surely lead planners to examine a wide variety of techniques and innovations, including:

(1) transporting retarded in need of specialized services;

(2) transporting staff to various communities, "circuit" basis or in a mobile unit;

(3) utilizing existing residential facilities for increased outpatient use;

(4) utilizing foster or "short stay" homes;

(5) establishing small boarding homes;

(6) bringing children and parents to community centers;

(7) developing new modes of contact and communication: radio, television, telephone, and correspondence services.

(8) providing in-service education for the staffs of community health, education, and social agencies, as well as for members of the clergy and various service organizations.

(9) training rural specialists or "area organizers" for the retarded.

Today, many of the needs of the retarded in sparsely populated areas are not being met. The final answer will require considerable creativity and flexibility in programming, as well as substantial financial support.

## REFERENCES

Annas, P. A. *Development of a Program for Mentally Retarded Children in Rural Schools 1958-1959.* Augusta, Maine: State Department of Education, 1959.

Hurder, W. P. State planning and coordination of resources for exceptional children. Paper read at Annual Meeting of the Louisiana Council for Handicapped Children, Alexandria, Louisiana, October 11, 1962.

Jordon, J. B. *Special Education Services in Sparsely Populated Areas: Guidelines for Research.* Boulder, Colorado: Western Interstate Commission for Higher Education, 1966.

Melcher, J., and Blessing, K. Special education for rural retarded youth, *Exceptional Children,* 23:207-210; 214, 1957.

The President's Panel on Mental Retardation. *A Proposed Program for National Action to Combat Mental Retardation.* Washington, D. C.: U. S. Government Printing Office, 1962.

# PROJECT 6 — WISCONSIN

Paul Ansay, ACSW

Project 6 is a program to enable a rural area to develop services for the retarded by providing that area with consultative guidance and partial financial aid. Officially known as "The Community Services Demonstration Project for the Mentally Retarded in Southwestern Wisconsin," this five-year project which will end in 1970 is supported by funds from the U. S. Public Health Service and administered by Central Wisconsin Colony and Training School, Madison, Wisconsin.

The project is based on the recognition that the retarded individual can and must receive care, training, and assistance as much as possible in his own home or community; that the community generally is a favorable environment for the development of the individual's maximum potential; and that the institution should play a long-term role only when it is impossible for the individual to be cared for in his own community.

## Problems in Programming

With the emphasis in recent years on developing community programs to allow the retarded to fulfill their maximum potential while remaining in their home or community, many efforts, haphazard and fragmented as well as coordinated and comprehensive, have begun along these lines. To date, emphasis on developing community programs has been centered in urban areas. Rural areas have lagged far behind in the development of comprehensive programs for the retarded. The needs of the retarded are, of course, no less in rural areas, but the problems of developing and maintaining services for meeting these needs are in many ways greater. Some of these problems follow:

(1) Services for the retarded often have not developed in rural areas due to the transportation problems involved in bringing people together in an area of low population density.

(2) In a rural area the understanding and awareness of the retardate's needs and the subsequent impetus to serve him have suffered from the relative lack of exposure to information about retardation.

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(3) In a rural area there is often a lack of facilities such as day care centers, sheltered workshops, and special education classes to serve the retarded.

(4) Most rural areas lack an organizational structure for proper indentification, treatment, and referral of the retarded.

(5) There is an extreme shortage of trained professionals such as phychologists, social workers, public health nurses, and physicians who can offer services to the retarded and their families.

(6) The lack of business and industry handicaps the development of vocational programs and job placement for the retarded.

Finally, parents of the retarded in a rural area often cannot afford the cost involved in transportation or child care necessary to attend parent group meetings or to take advantage of counseling and diagnostic services for their retarded child.

### Description of Project Area

The six-county rural area selected for this demonstration project is well suited for pursuing the project objectives. The total population of the six counties is less than 15,000. The largest county, Grant, has 45,000 people and the smallest, Crawford, has 15,500. Few communities have a population of more than 2,500; and two counties have no community of more than 2,500. The largest community in the entire area has a population of about 7,000. The entire six-county area, composed of Grant, LaFayette, Iowa, Richland, Crawford, and Sauk counties, is about the size of Connecticut. The population density is quite low, averaging about 30 people per square mile compared to a state average of 72 per square mile.

The per capita income is well below the state average, but is comparable with other rural areas in and outside of Wisconsin. There are no large industries; the labor force is employed chiefly in forestry and farming.

Wisconsin has a tradition of home rule. Even beyond such tradition, however, these six counties are unusually conservative and slow in the development and acceptance of any program serving a public need. The programs and services required to provide a continuum of care for the retarded were not available in any of these counties. At the onset of the project there were only four classes per county for the educable mentally retarded. There were no day care centers, sheltered workshops, referral agencies, or diagnostic services. Only one county had an organized group of parents of retarded children.

With respect to the availability of professionals and public agencies which might assume a role in serving the retarded, it should be noted that the only public agency required by law to be present in every Wisconsin county is a department of public welfare. However, with the exception of the directors, none of the county public welfare departments in the project area had trained social workers. All of the welfare departments are currently understaffed. Although each of the six counties has a public health nursing office, the nursing office in two of the counties is comprised of a single nurse who usually does not have formal training in public health nursing.

In July 1964, only one county had a community guidance clinic. Its staff consisted of a full-time, trained social worker, a part-time psychologist, and a psychiatrist available once a week. In April 1965, a second county organized a community guidance clinic. No other county had psychological or psychiatric services available. None of the schools in the area employed a psychologist. All of the 95 physicians in the six-county area were general practitioners with the exception of one surgeon. There were no pediatricians, neurologists, or psychologists residing in the area.

### Ten-Point Program

With all these problems in mind, Project 6 began its 10-point program. Each point will be considered independently.

1. *Public Education.* Because of the importance of enhancing community understanding and acceptance of the mentally retarded, the project began very early in its existence to plan and coordinate an extensive campaign of public education. By making a slide program on mental retardation available to groups in the area, by circulating a project newsletter, and by involving local libraries and news media in the dissemination of information, a greater understanding of retardation, and often a desire to develop necessary programs on the local level, have been developed. In addition, parents of retarded children are now organized in all six counties under the Wisconsin Association for Retarded Children.

2. *Proffessional and Agency Information.* To be assured that the local professionals are kept informed of the new services being developed, the project sends relevant information to the physicians, lawyers, judges, dentists, school administrators, clergymen, and special education teachers in the area. Also kept informed are welfare workers, public health nurses, and agencies which deal with the retarded. Educational semin-

ars on retardation have been conducted for most of these professional groups.

3. *Fixed Point of Referral.* The basic purpose of a "fixed point of referral" in a rural area is to provide a selected individual who can be given information on the array of services and resources locally, regionally, and state-wide that may be available for the retarded. He must be familiar with the mechanics of bringing such services to the retarded or of referring the individual and/or his family to the necessary program or service. These functions are particularly vital in a rural area where finding the appropriate service is even more difficult than in urban areas.

It was first thought that in rural counties the fixed point of referral service could best be accomplished within the county department of public welfare. However, the fact that the fixed points of referral in the counties of the project area are located in different agencies shows that several different agencies can effectively assume this role.

The actual selection came about through personal contact by the project staff, and consultants of the State Division of Mental Hygiene. Each community agency was given an explanation of the purpose and functions of a fixed point of referral. This explanation was given to every agency in the county. It was then up to these agencies to decide among themselves where the fixed point of referral would be most appropriate. The main considerations were availability of staff, enthusiasm, and interest in the responsibilities of a fixed point of referral. For example, in Crawford County both the county nurse and the department of public welfare were interested in performing this function. The welfare department eventually assumed the role because it had a larger staff and was better equipped to handle the required functions. The Grant County Mental Health Clinic from its inception had offered diagnostic and evaluation services to the mentally retarded on a request basis. Because of the Mental Health Clinic's staff, interest and enthusiasm, they readily assumed the responsibilities of the fixed point of referral in Grant County. The clinic has now undertaken an organized effort to identify the mentally retarded, learn about their needs, and provide specialized services.

The following are acting as the fixed points of referral in their county: LaFayette — the sheltered workshop; Grant and Sauk — mental health clinics; Richland — public health nurse; and Crawford and Iowa — the county welfare departments. The project provides a 20 percent subsidy to the agency for the salary of the staff members acting as the fixed point of referral. Consultation and training also is provided.

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4. *Local Diagnostic Services.* Since there was a shortage of professionals available for diagnostic work, the project established a traveling diagnostic team comprised of a pediatrician and a psychologist with the fixed point of referral serving as the social work member of the team in his county. The fixed point of referral provides, in advance, the usual family social history as well as routine referral information and any medical, psychological, or other prior evaluations that may be available. When the fixed point of referral has a sufficient number of referrals, the project coordinator arranges a date for the team to evaluate these children.

As of July 1, 1967, the traveling diagnostic team had examined 167 children, and found 117 to be retarded. Physical examinations revealed disorders such as minimal brain damage, seizures, cerebral palsy, mongolism, and multiple congenital anomalies. The team counsels the parents and recommends the appropriate service for their child. A majority of the children have been placed in the recommended program or seen by the recommended agency.

5. *Home Training Specialist.* The inclusion within the demonstration project of a home training specialist program once again reflects the broad goals and objectives of the project: to provide the continuum of care necessary for the retardate beginning at as early an age as possible, to permit the retarded individual the development of his maximum potential, and to prevent institutionalization whenever possible. Each of these goals is well served by a home training specialist program in any community.

The home training specialist provides in-the-home counseling and demonstration in areas such as feeding, toilet training, discipline, ambulation, and early education and training of the retarded child. She counsels parents on how to teach and provide recreational activities for their child, and she provides them with instructional material and special equipment.

The home visitor is employed by the project to function in the entire six-county area. It appears, however, that a home visitor could be better utilized in a work area of one county or one city with the office being centrally located to allow more time for planning programs and to reduce traveling time. The home training program has been well accepted throughout the project area. In July, 1967, the home visitor was seeing 57 children. Referrals for this program are received and coordinated by the individual fixed points of referral in each county.

The home visitor is also participating in the staffings of the traveling diagnostic team. These semi-monthly meetings are beneficial to both the home visitor and the traveling team. If the child being seen by the team is being seen by the home visitor, the home visitor is asked to give the team background information on the case. This coordination helps the team to make the most appropriate recommendations to the family. If the child being discussed by the team is not being seen by the home visitor, the home visitor can offer the parents suggestions on how to care for their child.

A foster grandparent proposal has been developed by the Project to show the possible use of foster grandparents in rural areas under the supervision of the home visitor. This proposal would involve two foster grandparents in each county who would be trained by the home visitor to carry through on the various plans for retarded children in their county. This would result in more frequent visits to the home of the retarded by the foster grandparent, thus giving the mother a more continued assist in her daily schedule with the child. The first thought was that this proposal would be implemented through the Project via a grant from the Administration on Aging, Office of Economic Opportunity. In order to directly involve the project area in the foster grandparent proposal, however, the Community Action Program Agency that serves five of the six counties in the Project area is being approached to undertake this proposal.

The utilization of the *Division of Mental Hygiene Patient Characteristic Check List* and the *Central Wisconsin Colony Adaptive Behavior Rating Scale* will facilitate data collection on behavioral characteristics of children served. Data collected will allow for several comparative studies concerning the identification of specific behavioral class activities found in common between those children in the community and those in the institution. This information will allow for a greater contribution to be made by the institution staff in programming for the community child being served by the Project's home visitor.

6. *Community Placement Worker*. The community placement worker places back into their counties of legal residence Colony patients who have achieved their maximum benefit from institutional living. There are 187 patients in the three Wisconsin Colonies who have legal residence in the Project area. These patients, who are considered by Colony staff to be in need of general nursing care or family care, are placed in their natural homes, private nursing homes, county homes, or family care homes.

Natural home placement is sought first for Colony patients, who usually are children in need of individual attention and affection which only can be provided by a family. The community placement worker visits the patient's parents and discusses the possibility of their accepting the child back from the Colony. Local community services for retarded children are described. These services include special education classes, day care centers, counselling clinics, county nurses, child welfare workers, associations for retarded children, as well as the project's home training specialist.

If the parents are unable to take back their retarded child in spite of availability of community services, foster home placement is considered. These foster homes, called family care homes, are established, financed, and supervised by the Colonies. Patients who cannot go back to their natural homes and who are in need of family living are placed in these family care homes. Group homes serve retarded patients in need of a family living situation and peer relationships.

Private nursing homes and county homes are used for patients who, because of behavioral or medical problems, cannot live in a family situation. There are 25 nursing homes with 647 beds and five county homes with 541 beds in the Project area. Temporary care homes are needed in each county to supply temporary emergency care for retarded individuals living in the community. Such a need arises when a parent becomes ill, as hospitalized, or is in desperate need of a vacation away from the retarded member of the family. The Colonies provided emergency temporary care on a limited basis, but county temporary care homes could meet more fully the growing need. Financial support for temporary care homes could come from county welfare funds, parents using the homes, associations for retarded children, and other sources. Temporary care homes also might be used by other foster parents in need of a rest away from their foster children.

County foster homes are used for retarded individuals who cannot live in their natural homes and are in need of family care rather than institutional care. The community placement worker's job is to work closely with child welfare workers in project counties to recruit these foster homes. After these homes are studied and licensed, and retarded children have been admitted, Project staff serve as consultants to the foster home supervisor.

7. *Special Education.* The State of Wisconsin under the Bureau for Handicapped Children allows a generous subsidy for special education classes. However, the Bureau, of course, requires psychological testing of retarded individuals before subsidy can be authorized. Since psychological services were not available in the school systems of the area and since testing by the Bureau requires a long waiting period, the Project hired its own psychologists to do the evaluations. The Bureau for

Handicapped Children designated the school districts where testing seemed most urgently needed, and the Project psychologists identified 153 retarded children.

Eventually, the Bureau and the Project encouraged a local agency, the Cooperative Educational Service Agency (CESA) to employ a school psychologist to take over the testing. The 19 district CESA's in Wisconsin, set up by the Department of Public Instruction in 1965, are agencies through which schools can purchase specialized services. Thus, a local agency, using local school district funds to employ school psychologists, has assumed the responsibility of providing testing for special classes.

The number of special classes in the area has doubled. Several of the new special class programs are full-day trainable classes, high school, and work study programs. In order to assist in recruiting special teachers needed for the area, the Project has asked local Associations for Retarded Children to encourage their local high school students to consider a career in special education.

A program on *Teaching the Mentally Retarded Child,* held at Central Colony for school administrators and special class teachers from the Project area, further stimulated interest in the development of special classes and interest in the retarded. Wisconsin State University, Platteville, which is in the area, is moving toward the development of an educational program to provide training for special education teachers.

8. *Day Care Programs.* The Project has worked closely with parent groups, the fixed points of referral, and local civic groups to set up day care centers for retarded children. The Project provided these groups with basic funds and information on day care and brought them together with the Day Care Consultant of the Division of Mental Hygiene. Eight day care centers have been set up in the Project area. The centers were established within the guidelines of the Division of Mental Hygiene in order to qualify for state support. Six of the centers have developed the level of standards necessary to receive the 40 percent state matching fund, and four of them are financially independent of the project. In addition, the parent groups which are helping to sponsor the centers have been encouraged to develop sources of income to insure the permanence of the centers.

The children in the centers are improving their basic motor skills and are learning socialization. The more capable are prepared for entrance into special education classes and several have successfully made this transition. The functions of the centers may eventually change to serve the younger and older age groups as the special class programs continue to develop.

9. *Sheltered Workshop.* Through the initial use of Project funds and through Project consultants, but particularly through the hard work of the LaFayette Association for Retarded Children, a sheltered workshop was set up in Shullsburg. The workshop served 34 clients, and 11 of these were placed in jobs outside the workshop. The Division of Vocational Rehabilitation, which had taken over the support of the workshop, recently suggested that the workshop be changed to a work adjustment program in order to receive more clients.

Because of the workshop's lack of clients, it appears that a workshop in a rural area must not limit its services to retarded clients, but must serve all handicapped individuals in the area. Another factor to be considered is the skepticism with which a workshop may be viewed by conservative, rural residents. The image of a workshop must be good in the eyes of those who are in a position to refer clients to it. Schools are a particularly important source of referral, and they often mold public opinion about a service.

10. *Recreation.* The Project presented a seminar on camping for the retarded in March 1966. This seminar stimulated local residents to set up a camp, held that summer for 58 retarded children from the Project area. The camp is incorporated under the title Southwest Badger Camp and has a board of directors made up of representatives from each of the county Associations for Retarded Children in the Project area.

The campers were between the ages of 7 and 20, toilet trained, and ambulant. Through a stimulating environment and program, the camp provided learning, socialization, and character development while providing enjoyment of the outdoors and healthy exercise. The campers stayed for one week and lived in dormitories with one counselor for every three children. The counselors were students from Wisconsin State University, Platteville, and were genuinely creative and imaginative.

The camp's daily activities consisted of games, music, arts and crafts, nature studies, hiking, campfire programs, and cookouts. The camp activities were directed by a staff which included the director, program, craft, and nature directors, and counselors.

Acting on the success of the 1966 camp session, the Board of Directors decided to have two, one-week sessions in 1967. The camp this year served 66 retarded children from ages 7 to 13 the first week. Recognizing the need to provide a camping experience for retarded young adults, the camp also served 4[illegible] persons from ages 14 to 35 the second week.

The six parent groups conducted fund-raising activities for the camp. Outstanding among these was a concert tour by the choir of St. Coletta's, a private school for the retarded in Wisconsin. The concerts drew 2,000 people and raised more than $2,000 for the camp.

A continued interest in recreational program, particularly for older retarded individuals, is being further developed. For instance, in Prairie du Chien, older retardates are being given bowling lessons by the manager of the local bowling alley.

### Conclusion

In preparation for the phasing out of the Project, active community involvement, both personal and financial, has been developed. In total more than $228,000 in new funds have come from sources other than the Project for the development and maintenance of community resources for the retarded in the area. In the remaining years of the Project, continuous planning and implementation of further community support will be developed.

Of great value has been the Project's permanent advisory committee, composed of representatives from Central Colony, Wisconsin State agencies, the University of Wisconsin, and the Wisconsin Association for Retarded Children. This committee has been a useful medium of communication between State agencies and Project staff, and it has provided helpful suggestions for pursuing the Project's objectives.

There has been an increasing interest by State personnel in the responsibilities and functioning of the fixed point of referral and the home training specialist. In answer to this request a proposal on training and a listing of the responsiblilties of the fixed point of referral and home training specialist were developed by the project for the State Department of Health and Social Services, Division of Mental Hygiene.

Thus, neither the community, the state, nor the Project has neglected the issue of seeking to continue these programs in the rural area of the Project.

# DIAGNOSIS AND FOLLOW-UP IN NONMETROPOLITAN AREAS

Donald St. Lawrence, MSW

In thinking about services for the mentally retarded in nonmetropolitan and rural areas, it would seem to me we are faced with two basic questions: (1) the structure and auspices of such services; and (2) service content. The following report attempts to give an overview of both areas.

## Rural Zones

One of the important characteristics of the nonmetropolitan and rural areas is the coverage of a large geographic area. The distances, and the number of governmental units contained in such areas are significant planning considerations. In Illinois, at this time, the basic planning unit for mental health services is the multicounty zone. Outside of the metropolitan areas, these zones are usually composed of 15 to 20 counties, with more than a half-million total population. There are few mental health resources, especially with respect to diagnostic and follow-up services for the mentally retarded. Even in areas with mental health services, there are often significant gaps in coverage due to staff shortages, which render facilities incapable of providing the amount of service needed in the area for which they assume responsibility.

## Rural Programs and Organization

We must first look at some models for providing the needed diagnostic and follow-up services in areas where they do not exist. It should be emphasized that the models discussed in this paper are but one way of approaching the problem, and it is hoped that they can serve as stimulators of thinking and discussion.

The structure of services in the nonmetropolitan area can be discussed at several different levels. First there is what may be referred to as the local facility, usually a multi-purpose state-aided community mental health center, designed to serve a population center, such as a city or county. This type of local facility usually develops in cities and counties with a population of approximately 40,000 or more. They

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are most feasible where both the size of the community and its level of professional and social sophistication are compatible with attracting and holding specialized mental health personnel.

The Springfield Mental Health Center is a good example of this type of facility. The Center has a staff member who devotes a large portion of her time to giving direct diagnostic and follow-up services to the retarded, and full diagnostic and treatment resources are available. Educational and consultation services also are provided.

In Quincy, an approved Federal staffing grant will provide a network of services in five counties which will include diagnostic and follow-up services, as well as other programs, for the mentally retarded. In effect, the staffing grant will result in welding a large state hospital, the psychiatric unit of a private hospital, two general hospitals with emergency beds for crisis care, a mental health center, and a zone center into a comprehensive care-giving network. Service will be given on the criteria of patient need and ability to profit from the program, rather than on the basis of any "label."

A second type of local organization is called the "multicounty contractual arrangement." This can be made up of two to five counties (or more) where, by contractual arrangement, these counties combine to give diagnostic and follow-up services to the retarded, usually as part of a broader program. This can be done under the auspices of governmental bodies, such as the county boards of supervisors, or it can be done by private agencies, such as mental health societies or associations for the mentally retarded. The most common arrangement is where one or more counties agree to purchase some service from an already existing agency. In Zone V, for example, the Mental Health Association of Logan County underwrites the cost of clinic services for its clients at the Springfield Mental Health Center. A parents' group in Carlinville contracts for a specific amount of time from one of the staff members of the Springfield Mental Health Center, who is particularly expert in working with the retarded. These services are simple, prototype arrangements.

The multidistrict special education systems, following the passage of House Bill 1407, will result in school districts and entire counties banding together to give services needed to cover a rather large geographic area. The Four Rivers District in Zone V, which covers eight counties, entered into such an agreement. Previously, the individual districts could not provide adequate services. Similar types of organizations should be established to extend services to the mentally retarded and emotionally disturbed in all areas.

Permissive legislation enabling counties to levy taxes for the provision of such services should provide an eventual financial base from which these services can be organized. It is well to point out that although local services can be provided under various auspices (e.g., the United Community Fund, or parent associations), adequate coverage for all citizens, regardless of income level, will be possible only when a sufficient, dependable source of revenue is available. Local and county tax programs will provide such a financial basis. I am becoming more and more of the opinion that while private and semipublic resources are of great importance, and in many instances give a high quality and pioneering service, they are not adaptable to doing a rather high volume mass coverage over relatively large geographical areas.

The second level of services is state services, organized at a zone or a multizone level. Diagnostic and follow-up services are becoming primary services at the Zone level. Zone programs, however, should exist only when they are too costly to be financed by a local facility, or when they are so specialized that their use is infrequent enough to make providing them on the more local level not economical in either monetary or staff terms. Examples of this category include certain relatively lengthy inpatient diagnostic and programming services for the retarded, some highly sophisticated speech and hearing evaluations, and perhaps some unusually complex neurological and medication regulation problems.

One of the primary difficulties between these two levels of service is that some of the zone programs could very well be done by local facilities. In most cases we are doing these services where local facilities do not exist. This situation presents one of the biggest planning dilemmas. On the one hand, one feels a strong and compelling obligation to meet the needs of the retarded person, his family, and the community. On the other hand, trying to meet all these needs on the zone level deters communities from coming to grips with their problems and from developing services that would, in the long run, be much more adequate. The zone's task is to meet current needs for services while, at the same time, working actively with communities to help them establish adequate local resources to give the type of services that any community can reasonably be expected to provide. Prior to the development of the zone structures, basic diagnostic and follow-up service developed out of large state institutions, such as a state hospital, a state school, or a specialized institution, e.g., Institute for Juvenile Research. This type of arrangement is described by Butler and Bramwell (1964) in their article on the development of a traveling clinic program out of the Sonoma State Hospital in California. In Illinois, this was the level on which the regional child guidance services of the Institute for Juvenile Research were organized, with a headquarters clinic in each region, and fixed interviewing, or examining points, manned on a regular part-time schedule.

Another varient of the structures described above would be the state-wide service given from one central point. In most large states, such as Illinois, this structure of service is impractical. There was a time, however, in Illinois when both Child Welfare and Child Guidance Services were organized on such a basis. It would seem unlikely that this form of structure will have much future relevance.

Another aspect of structure and auspices is related to community acceptance and participation. The prevailing belief in Illinois is that communities prefer services that are at least in part locally financed, and in the main, locally administered. Experience would seem to indicate that facilities of this type are those which command the maximum amount of citizen participation and interest. It gives the community a sense of having their own service, one which cannot be duplicated. This is an important value, which should not be overlooked in planning. The local agency with maximum community participation is in the best strategic position to become aware of, and to respond to the idiosyncratic needs of its community. As mentioned above, local financial participation can come either from voluntary giving (e.g., United Community Fund or Mental Health Association) or from city or county taxes. The policy-making body of the local facility usually is a lay board. The same is true for the local facilities providing day care and educational services to the mentally retarded. Both of these agencies draw additional community personnel into their educational and service orbits through volunteer programs and community education programs. Their local status and broad base of lay participation often gives them a favored position with local news media as well.

In the multicounty arrangement, services would result from contractual agreements between various groups, including governmental agencies, such as county boards of supervisors; groups of parents of the retarded from several counties; or several mental health associations. These arrangements probably would entail the establishment of an advisory or policy-making board, depending upon the terms of the contract, to implement the contractual service and to recommend alterations in that service to the participating sanctioning agencies.

With the foregoing in mind, it seems possible to establish some planning guidelines for organizing or augmenting services in nonmetropolitan areas. It has been the experience of the Department of Mental

Health and others (e.g., Butler and Bramwell, 1964) that service is most meaningful to the community when organized at the local level. Planning decisions on how to assist a community in developing or expanding local services need to take into consideration such factors as population density within the immediate area and the economic and cultural readiness of the community to support the proposed services. Accordingly, in predominantly rural communities, local services may be most feasible when provided through multicounty service contracts. These have the difficulty of being somewhat less flexible than the usual clinical service provided by a single city or county, as they must operate on a common denominator of agreement among several governmental agencies or voluntary groups. Furthermore, the administration is removed from any single agency or group. The multicounty approach, however, is economically feasible in areas of low population density and enables people living in the area to consider these facilities as "their own." One of these two forms of local service should exist in every geographic area.

In planning, the first two structural types are considered to be primary services, while the third, with its characteristics of being part of a state-wide department, is considered to be secondary. Without active programs existing at both levels, however, local and multicounty facilities will not have back-up resources they need, and the state-operated facilities become isolated from the citizens that they serve, and therefore, are used less efficiently and effectively.

## Planning

We are coming more and more to rely on the concepts of multilevel organization and financing. The demands for service are so broad and complex that no one sector of the field can do the entire job. In the nonmetropolitan area, the single community cannot be self-sufficient. When we assess the mental health and mental retardation needs of our citizens, and design programs to meet these needs, we should be able to combine single community, multicounty, and state resources. We have to design a balanced program which emphasizes the interdependence of one level upon the other. This is emphasized because of the great temptation to seek the simplicity of having a program that is controlled and operated completely at only one level. This solution is achieved at the expense of the richness that comes to a program with many able resources. Program planning should provide structures that facilitate the use of a variety of combinations of services and financing patterns.

Concepts of voluntary giving and local-state matching funds is traditional in Illinois. We have added to our armamentarium by the relatively recent legislation allowing counties to raise tax funds for mental retardation and mental illness. The Federal Government is also an increasing source of funds that can be used at all levels in the service structure.

### Community Response

For some time there has been stress on the importance of knowledge of the community. Yet, the state of our art has been such that only in a limited number of situations has the community really been made a part of the comprehensive diagnosis. So many of our therapeutic attempts fail because of lack of proper community knowledge. Dr. Chess (1962) states that "society makes certain demands on families which may be quite realistic, as opposed to the hopeful expectations of the therapist. The therapist may encourage a parent to expose a child to life, travel, etc., while society has different expectations and demands greater responsibility on the part of the child." Knowledge of community attitudes and expectations is not only important in the diagnostic relationship with the retardate and his family, but it is also vitally important in program planning both for work with the individual retardate and the general community.

Incorrect assessment of a community's readiness for a given program may result not only in the lack of acceptance of that particular program, but can also engender negative attitudes on the part of the community which prevent the establishment of other programs, or adversely affect those already in existence. There is also danger of underestimating the community's readiness and resources. This can cause us to be too timid in programming and can, through lack of recognition, cause us to overlook many potentially valuable resources within the community. Here, as with the retardate and his family, the process of community diagnosis and follow-up also is a continuing one. We have the responsibility not only for assessment, but also for design of both service and educational programs that will produce positive movement in the general level of community knowledge and acceptance of retardation.

I would like to conclude this presentation with a brief comment concerning the relationship of mental retardation and mental illness as it affects diagnostic programs. For a long time there has been a wall between mental illness and mental retardation. This wall is being breached. As stated by Butler and Bramwell (1964, p. 288):

> **We have found that it is not wise to limit the clinic to problems of mental retardation alone. The communities served are relatively unsophisticated as far as the identification of mental retardation is concerned. Many mentally retarded patients referred are not considered such by local agencies. Conversely, many patients referred as mentally retarded were found to be of normal intelligence.**
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> **In these isolated areas, there is often more of a stigma attached to mental retardation than in urban areas. It can be difficult to get parents to bring their children to a clinic labeled as a mentally retarded clinic, but there is little objection to a psychiatric clinic. The parents may deny that their child is retarded, but they usually cannot deny that they are faced with a child with a problem. Furthermore, most people in these communities do not think in terms of diagnostic categories. They see patients in terms of community problems (I am not sure that we as professionals have always been able to maintain this rather unsophisticated but important attitude toward those we serve). If the clinic is willing to accept the most pressing cases, regardless of category, community support of the clinic is strengthened.**

It would seem that this integration of services is not only valid on the community level, but also can be adopted as an overall service-giving philosophy on the entire diagnostic and follow-up level, whether this be an outpatient service in the local community or an inpatient service given at a state facility. On all these levels it would seem that our primary concern must be connecting people with needs and service, rather than matching diagnostic categories to programs.

## REFERENCES

Butler, J. A., and Bramwell, D. M. From trial and error—How we developed a traveling clinic program. *Mental Retardation*, 35: 286-289, 1964.

Chess, S. Psychiatric treatment of the mentally retarded child with behavior problems. *American Journal of Orthopsychiatry*, 32: 501-507, 1962.

# SATELLITE PROGRAMS FOR THE RETARDED IN RURAL AREAS

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It is a truism to note that relatively little has existed in the way of programs and resources for the mentally retarded in rural areas. Rothstein's (1961, p. 481) statement remains tragically accurate: "The truly forgotten child is one who lives in a rural area." There have been, of course, certain notable exceptions. Perhaps the most exciting has been Project Six in Wisconsin (1967), or more specifically, "A Community Service Demonstration Project for the Mentally Retarded in Rural Areas." A report of this program will be found elsewhere in these proceedings. This comprehensive project may well prove to be a prototype program; one that will provide a broad and experiential framework for the guidance of other communities.

While there are some facilities for the mentally retarded located in rural areas, these generally are designed to serve relatively wide geographical areas. The Marbridge Ranch in Texas, for example, is rural in location but its training programs are open to any qualified mental retardate in the state (Peck, 1963). Numerous outdoor and recreational centers are likewise generally rural in setting, yet limited in services and open to sponsored individuals from a broad area.

Urban areas, on the other hand, are, comparatively speaking, generously endowed with developmental and work training facilities of all kinds — sheltered workshops, day care centers, day camps and the like. However, such services are rarely designed and available for the mentally retarded in rural areas. Too often these urban facilities provide only diagnostic and evaluation services to the retarded, rural child, and subsequently he is sent home with nothing programmed for him in the future. Some of the more fortunate individuals may be held over at a workshop in a boarding home arrangement. All in all, the needs of the rural retarded were and are not being adequately met; and the

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loss in human resources and human dignity was and still remains a blight on our technological resources and ingenuity.

### Developments in Southern Illinois

The problem of providing adequate developmental and work training services to the mentally retarded was of acute concern to the communities of Southern Illinois in mid-1950, as it was for other handicapped persons in that area. This led to the formation of an area-wide committee made up of interested and knowledgeable representatives of communities in the lower 16 or 20 counties. Prominent, or even foremost, on the agenda was the need for a resource to evaluate, train and place mentally retarded individuals in the area. Since the favorable efforts of other communities along a similar line were then most encouraging, it was decided to proceed with a project to evaluate and train in a sheltered workshop as many of the rural mentally retarded as the facility could handle (Kolstoe, 1960). It must be remembered that Southern Illinois is a highly dispersed and economically depressed area. Unemployment runs as high as 15-20 percent in some locations, and counties range from less than 20,000 to 35,000 or so people.

The combination of a vocational evaluation unit and a sheltered workshop was developed for both males and females, and the original plan called for commuters to come from as far away as 30-40 miles. Problems of transportation, however, led to the development of a dormitory unit, and it was found that 15-20 miles was the maximum distance from which individuals were likely to commute. Moreover, unless transportation was subsidized and managed by a governmental unit, e.g., a school district or the Division of Vocational Rehabilitation, attendance was sporadic and intermittent. The Employment Training Project, as it was then known, became a limited but functioning evaluation-training-placement and residential center and its success was pronounced. Later, experience with a work-study program for the retarded student enriched further the curriculum content, with special attention given to pre-vocational and functional living skills as a prerequisite leading to fulfillment and economic sufficiency (Kolstoe and Frey, 1965). Even with the advent of this provocative and significant program, it was quite obvious that it could serve only a limited number of mentally retarded in Southern Illinois. Furthermore, such a residential evaluation and training project could only meet part of the needs of this group.

## What Was Needed

Problems of transporting the retarded to a central facility and the limited availability of services added to the area-wide Committee's concern for the handicapped in the region. The decision was to conduct a survey of the needs of all severely disabled people in Jackson County, which county was considered somewhat representative of the area (Shafter and Renzaglia, 1962). Some interesting conclusions about transportation were made. For one thing, families of rural retarded did not object to taking or having their children taken to particular communities with which they identified or which were their shopping-trade center. (Thus, for families living in the western part of the county, Murphysboro was the center of the area and an ideal location for a rehabilitation facility, but Carbondale, only six miles away, was unacceptable. On the eastern side of the county, the identification was understandably with Herrin or Marion, and similar involvments were noted in other directions.) Therefore, it became obvious that if facilities were really to serve the retarded in these rural areas, such should be located in communities where families have their closest ties. Yet, it was recognized that such a proposal was neither professionally nor economically feasible. It would be impossible to replicate workshop after workshop throughout the area. Indeed, the oft-mentioned guideline of a sheltered workshop in an area of at least 50,000 people immediately ruled out the notion of multiple workshops, for nowhere in Southern Illinois are cities of this size to be found.

What then was (and is) at least a partial solution to these sometimes discouraging but reality factors or conditions? The conclusion was to develop a comprehensive and central "mother" facility and, where indicated, a network of complementary satellite units or programs, coordinated so as to avoid competition and duplication. Such a program would embrace a wide variety of services to the mentally retarded, and an adequate treatment of such is outside the scope of this paper, but for the sake of illustration, only the sheltered workshop and a corollary day care center aspects will be discussed. Yet, the underlying rationale is most likely applicable to other programs.

The facility envisioned was a comprehensive developmental and work-training center for the assessment, training and development of the mentally retarded culminating in ultimate employment and enriched living. To this end, the center had to contain various preparatory and training units — these were:

**ASSESSMENT (FUNCTIONAL LIVING AND WORK) UNIT. A unit to thoroughly appraise an individual's general life style, abilities and**

potential for work by use of standardized instruments, work samples, simulated tasks, work try-out, situational observations, supervisors' ratings and so on.

**DEVELOPMENTAL TRAINING UNIT.** This will involve a program to prepare retarded individuals in both functional, and work-related educational skills, improve their interpersonal interactions and social skills, as it will also endeavor to enrich their lives with recreational and leisure-time activities. This unit will be most intimately involved with those retardates in the day care operation.

**WORK ADJUSTMENT UNIT.** In this unit individuals will be trained in work habits and the pre-vocational and interpersonal skills important in work settings.

**SKILL TRAINING UNIT.** Clients will be trained "on the job" in this unit in the work skills for which they are most suited. (While this will be done primarily in line with contracted work, all other units of the Center will be utilized as required for this purpose.)

**JOB DEVELOPMENT.** Designated individuals will be responsible for developing jobs preparatory to placement. This will be achieved through contracts with agencies, employers, service groups, etc.

**PLACEMENT SERVICES.** The cooperation of the Division of Vocational Rehabilitation and the Illinois State Employment Services will be sought in the quest for employment for rehabilitated clients.

**COUNSELING.** This service will be an integral aspect of the whole program. Qualified personnel should provide direct client service and supervise counseling trainess from cooperating University department.

**ON-THE-JOB TRAINING.** A unit composed of professional staff to supervise trainees in actual work situations in the community. Work assignments with service stations, laundries, restaurants, automotive repair shops and the like are contemplated.

**TERMINAL WORK.** A certain number of clients will always be unable to operate successfully outside of a workshop center. It is expected that such clients will be moved into workshops in their home areas, as these are developed. Meanwhile, the Center will continue terminal employment for this group.

**SATELLITE DEVELOPMENT AND COORDINATION.** Staff in this unit will serve as community liaison and development personnel—encourage and arrange for communities to organize their own programs. It is expected that satellites will be independently operated by local groups, each serving its own needs, and that the Center's role will be advisory, supportive and augmentative.

The success of such an ambitious undertaking depends necessarily on the extent and quality of the staff in each of the units. Generous grants for a day care center from the Illinois Department of Mental Health and from the Rehabilitation Services Administration for improvement of services and facilities made available financial resources to employ appropriate staff. Most dispersed areas were and are having considerable difficulties finding and holding qualified staff. Fortunately, Southern Illinois University decided to continue operation of the Center, in close cooperation, of course, with other agencies and communities, which made it a little easier to recruit and hold the necessary staff. This then became a most potent laboratory for the University for training rehabilitation specialists and for research in the behavioral areas. Collaborative efforts of this sort between a University, agencies and various communities are not observed frequently, and it probably was the real reason for the program's success.

## The Future

Plans are now in the making to firm up the full role of this comprehensive program as a central, coordinating facility for the Southern Illinois area. Added support and encouragement was given this plan by Zone 8, Department of Mental Health, when a full-time and part-time liaison person on the Zone staff was assigned to the Center to assist in community efforts, satellite development and to implement the day care program for the adult mentally retarded. The A. L. Bowen Children's Center also graciously assigned one of their staff to act as regular consultant to the Center's staff. A full complement of qualified staff is making it possible for the Center to:

1. Maintain constant liaision with communities in order to stimulate them to develop the initiative and resources to provide for their retarded citizens. In the past these efforts have been met with a willingness on the part of the communities to do something but a lack of "know-how" in respect to how to start a program, where to get funds and what kind of activities to include in a program. This kind of "birth trauma" is now dispelled, since the parent facility has staff to help communities get into operation. Satellite programs would range from a single person affair to a large operation training and employing many.
2. Recruit and train staff for satellite programs in all phases of center operations. Periodic meetings will also be held to keep such staff alert to new procedures or emphases. Prior to the opening of any satellite program, the staff then would be trained and helped to set up the necessary fiscal and other operations indicated.
3. Process and evaluate all area clients through the central facility, and with each assignment to satellite programs will be a suggestive plan for the retarded client. Assignments will be based on reality factors such as residence of the retarded, availability of the program most appropriate for him and the like.
4. Procure and administer subcontracts through the Central facility and apportioned out in whole or part to local facilities. As evident, this would eliminate competition and duplication of efforts. In addition, when indicated, satellite programs will be encouraged to manufacture or work on non-contract items, perhaps made of local products. At the present time, the central facility is now

**producing a number of non-contract items, some of which could be readily farmed out to satellite shops (bird houses, beach bags, floats, etc.).**

5. **Purchase supplies, materials, and equipment through a main unit, which should reduce cost and duplication of administration.**

The idea of a central coordinating facility programming for the mentally retarded probably is not new; but its successful implementation in a widely dispersed area is. Southern Illinois is now deeply in the throes of making it work. The central developmental and work training center is finally taking shape — staff positions are nearly filled, equipment and materials are being purchased, and modifications in building are in process. The word is out that the Center stands ready to help other communities. One community has already started the wheels in motion for quite a significant training and work center for the handicapped. Other communities are likewise pressing the staff for action. In five years or so, envisioned is a truly comprehensive central facility with at least 5-8 satellite units, serving some 16 counties in Southern Illinois. Some are aspiring for a sheltered work situation; others for training centers, while some communities look primarily to day care operations in conjunction with recreational programs. Then there are those who are moving toward multiple operations. There are truly exciting times ahead for those who work with the mentally retarded in rural areas, and man's ingenuity knows no limits.

## REFERENCE

Ansay, P. *Fourth Progress Report: A Community Service Demonstration Project for the Mentally Retarded in a Rural Area.* Madison, Wisconsin: Central Wisconsin Colony and Training School, 1967.

Kolstoe, O. P. The employment evaluation and training program. *American Journal of Mental Deficiency,* 65: 17-31, 1960.

Kolstoe, O. P., and Frey, R. M. *A High School Work-Study Program for Mentally Retarded Students.* Carbondale: Southern Illinois University Press, 1965.

Peck, J. R. *Clearing in the Wilderness.* Austin, Texas: The Hogg Foundation, 1963.

Rothstein, H. *Mental Retardation: Reading and Resources.* New York: Holt, Rinehart and Winston, 1961.

Shafter, A. J. and Renzaglia, G. A. *A Survey and Recommendations for the Disabled of Southern Illinois.* Carbondale, Illinois: Area Services, Southern Illinois University, 1962.